

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER 000020677A
 PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,711,910.28	ADJUSTMENTS	57,952.82
COVERED CHARGES	3,691,764.74	CONTRACTUAL ALLOW	2,908,905.10
NON-COVERD CHARGES	20,145.54	TOTAL MEDICAID LIAB	782,859.64
		LESS: COB	941.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	781,917.90

TOTAL NUMBER OF ADMISSIONS 89

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	102		0	72,666.99		5,858.16
ROUTINE NURSERY	30		0	11,112.90		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	132		0	83,779.89		5,858.16
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	186		0	270,839.44		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	186		0	270,839.44		0.00
TOTAL ACCOMODATIONS	318		0	354,619.33		5,858.16

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 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512,561.67	0.00	OTHER LAB	40,035.49	0.00
MED/SURG SUPPLY	83,238.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	563,217.36	0.00	EDUCATION & TRAINING	244.27	0.00
RADIOLOGY-DIAGNOSTIC	118,052.64	0.00	OTHER THERAPEUTIC SVC	0.00	4,645.98
CT SCAN	250,228.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,597.37	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	49,805.65	0.00	MRI SERVICES	62,273.31	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	281,898.16	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,225.22	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	430,531.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	183,892.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,603.49	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	302,394.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,199.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,899.58	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,460.37	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,558.97	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,645.85	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,752.96	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,807.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,851.42	0.00			
BLOOD	1,818.72	0.00			
BLOOD STORAGE & PRO.	10,628.57	9,641.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,426.71	0.00			
CARDIOLOGY	217,296.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,337,145.41	14,287.38
			TOTAL ACCOMODATIONS	354,619.33	5,858.16
			TOTAL CHARGES	3,691,764.74	20,145.54

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: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,126.01	ADJUSTMENTS	0.00
COVERED CHARGES	7,126.01	CONTRACTUAL ALLOW	806.57
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,319.44
		LESS: COB	6,319.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1		0	644.04		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1		0	644.04		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1		0	644.04		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,019.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,624.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,741.74	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95.68	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,481.97	0.00
			TOTAL ACCOMODATIONS	644.04	0.00
			TOTAL CHARGES	7,126.01	0.00

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

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

Run Date: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,208,788.08	ADJUSTMENTS	210,087.11
COVERED CHARGES	5,777,349.28	CONTRACTUAL ALLOW	5,359,307.63
NON-COVERD CHARGES	431,438.80	TOTAL MEDICAID LIAB	418,041.65
		LESS: COB	620.83
		LESS: COPAYMENT	1,053.00
		REIMBURSEMENT	416,367.82
		ALL OTHER	363,281.26
		FEE SCHEDULE-LAB	46,897.72
		INJECTABLE DRUGS	6,188.84
		TOTAL NUMBER OF CLAIMS	1,497

PIEDMONT WALTON HOSPITAL, INC
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PROVIDER NUMBER
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PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,158.76	3,904.39	OTHER LAB	44,784.06	0.00
MED/SURG SUPPLY	62,099.95	2,452.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	82.02
RADIOLOGY-DIAGNOSTIC	307,500.07	4,137.86	OTHER THERAPEUTIC SVC	0.00	34,884.76
CT SCAN	626,042.96	126,306.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,472.00	2,250.96	FEE SCHEDULE LAB	717,027.39	26,564.66
EKG/ECG	135,451.84	635.37	MRI SERVICES	51,326.04	9,355.02
IV THERAPY	6,886.65	2,643.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	333,128.14	21,231.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	204.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,136.04	19,195.53	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	151,056.55	7,719.88	AMBULANCE	0.00	0.00
GI SERVICES	51,849.72	1,186.01	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,293,362.10	32,589.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	146,644.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	152,730.90	42,108.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	706.64	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,365.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,020.84	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.16	4,838.46	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,147.81	1,171.36
LITHOTRIPSY	54,819.35	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,765.62	5,950.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,878.88	1,928.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,544.30	30,715.34			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,335.43	30,637.24			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	154,893.86	12,857.82			
			TOTAL ANCILLARY	5,777,349.28	431,438.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,777,349.28	431,438.80

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	184,418.03	ADJUSTMENTS	0.00
COVERED CHARGES	115,626.34	CONTRACTUAL ALLOW	65,109.68
NON-COVERD CHARGES	68,791.69	TOTAL MEDICAID LIAB	50,516.66
		LESS: COB	50,510.66
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

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

PIEDMONT WALTON HOSPITAL, INC
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 MONROE,GA 30655-3115

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 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	697.12	8,146.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,455.38	186.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,014.70	2,044.99	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,707.33	4,075.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,141.38	251.80
EKG/ECG	635.37	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,347.61	22,945.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	889.52	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,684.70	14,268.19	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,187.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,394.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,977.20	367.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	142.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	16,362.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,493.77	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	115,626.34	68,791.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	115,626.34	68,791.69

Report : CLM-0808-0
Process : CLMJ0800
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: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
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PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	729,525.02	ADJUSTMENTS	644.28
COVERED CHARGES	692,714.43	CONTRACTUAL ALLOW	678,488.11
NON-COVERD CHARGES	36,810.59	TOTAL MEDICAID LIAB	14,226.32
		LESS: COB	28.18
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	13,709.14
		TOTAL NUMBER OF CLAIMS	263

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
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PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,249.99	1,040.35	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	829.02	186.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,360.68	6,852.05	OTHER THERAPEUTIC SVC	0.00	2,751.80
CT SCAN	60,751.27	16,934.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,633.77	3,336.75
EKG/ECG	24,779.43	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,394.18	1,866.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	441,027.56	2,218.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,323.77	829.07
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,364.76	793.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	692,714.43	36,810.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	692,714.43	36,810.59

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: 08/23/2018
Run Time: 19:05:55
Page: 11

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER 000020677A
PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,426.49	ADJUSTMENTS	0.00
COVERED CHARGES	24,240.90	CONTRACTUAL ALLOW	12,937.24
NON-COVERD CHARGES	5,185.59	TOTAL MEDICAID LIAB	11,303.66
		LESS: COB	11,294.66
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26.70	13.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	753.72	0.00	OTHER THERAPEUTIC SVC	0.00	275.18
CT SCAN	0.00	4,707.33	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,050.86	189.58
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,349.57	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,060.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,240.90	5,185.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,240.90	5,185.59

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

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

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

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	10/01/17	THROUGH	08/23/18
SERVICE DATES	10/01/17	THROUGH	03/31/18
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: 08/23/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	10/01/17	THROUGH	08/23/18
SERVICE DATES	10/01/17	THROUGH	03/31/18
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0900-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
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Page: 1

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	10/01/17	THROUGH	08/23/18
SERVICE DATES	10/01/17	THROUGH	03/31/18
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0902-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0904-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,674.03	ADJUSTMENTS	720.76
COVERED CHARGES	36,346.95	CONTRACTUAL ALLOW	33,674.79
NON-COVERD CHARGES	327.08	TOTAL MEDICAID LIAB	2,672.16
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,672.16
		ALL OTHER	2,500.87
		FEE SCHEDULE-LAB	165.21
		INJECTABLE DRUGS	6.08

TOTAL NUMBER OF CLAIMS 18

Report : CLM-0904-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	966.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	552.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,333.22	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,027.54	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	933.35	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,082.72	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	451.12	327.08
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	36,346.95	327.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,346.95	327.08

Report : CLM-0906-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,509.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,509.75	CONTRACTUAL ALLOW	981.34
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	528.41
		LESS: COB	528.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	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	588.55	0.00	OTHER THERAPEUTIC SVC	0.00	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	921.20	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	1,509.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,509.75	0.00

Report : CLM-0908-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
SERVICE DATES 10/01/17 THROUGH 03/31/18
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,349.93	ADJUSTMENTS	0.00
COVERED CHARGES	2,349.93	CONTRACTUAL ALLOW	2,182.11
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	167.82
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	164.82
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0908-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 08/23/2018
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PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 10/01/17 THROUGH 08/23/18
 SERVICE DATES 10/01/17 THROUGH 03/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	123.78	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,181.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,349.93	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,349.93	0.00

Report : CLM-0910-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
Run Time: 19:06:23
Page: 9

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	10/01/17	THROUGH	08/23/18
SERVICE DATES	10/01/17	THROUGH	03/31/18
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0912-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
Run Time: 19:06:23
Page: 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	10/01/17	THROUGH	08/23/18
SERVICE DATES	10/01/17	THROUGH	03/31/18
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0914-0
Process : CLMJ0800
Location: CLMP8000

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

Run Date: 08/23/2018
Run Time: 19:06:23
Page: 11

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	10/01/17	THROUGH	08/23/18
SERVICE DATES	10/01/17	THROUGH	03/31/18
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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,225,711.90	ADJUSTMENTS	738,433.75
COVERED CHARGES	27,499,470.77	CONTRACTUAL ALLOW	20,228,107.22
NON-COVERD CHARGES	726,241.13	TOTAL MEDICAID LIAB	7,271,363.55
		LESS: COB	107,770.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,163,593.40

TOTAL NUMBER OF ADMISSIONS 608

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,247		0	3,075,124.00		245,993.00
ROUTINE NURSERY	213		0	163,086.00		71,253.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,460		0	3,238,210.00		317,246.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,016		0	2,597,233.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,016		0	2,597,233.00		0.00
TOTAL ACCOMODATIONS	4,476		0	5,835,443.00		317,246.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

CANDLER HOSPITAL
 5353 REYNOLDS ST
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,666,376.31	0.00	OTHER LAB	97,658.00	0.00
MED/SURG SUPPLY	520,016.00	1,660.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,898,404.30	9,772.00	EDUCATION & TRAINING	368.00	0.00
RADIOLOGY-DIAGNOSTIC	1,035,583.70	0.00	OTHER THERAPEUTIC SVC	0.00	172,222.00
CT SCAN	1,269,121.00	82,442.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	253,269.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	76,152.00	0.00	MRI SERVICES	294,119.00	0.00
IV THERAPY	364,405.00	7,549.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,518,769.84	13,014.87	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	157,049.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,557,258.00	1,677.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	488,729.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	170,996.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	535,914.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	284,146.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	117,150.00	0.00	INJECTABLE DRUGS	4,241,392.56	0.00
RADIOLOGY THERAPEUTIC	135,564.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	89,634.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	133,496.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	509,197.00	2,135.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	150.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	219,472.00	0.00
LITHOTRIPSY	33,391.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	117,945.00	7,270.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	514,004.00	54,001.26			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	91,555.00	57,252.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	133,366.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,376.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,000.86	0.00			
			TOTAL ANCILLARY	21,664,027.77	408,995.13
			TOTAL ACCOMODATIONS	5,835,443.00	317,246.00
			TOTAL CHARGES	27,499,470.77	726,241.13

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	684,368.49	ADJUSTMENTS	0.00
COVERED CHARGES	667,083.45	CONTRACTUAL ALLOW	398,649.44
NON-COVERD CHARGES	17,285.04	TOTAL MEDICAID LIAB	268,434.01
		LESS: COB	268,434.01
		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	62		0	58,856.00		4,800.00
ROUTINE NURSERY	14		0	12,073.00		6,699.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	76		0	70,929.00		11,499.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	13		0	29,601.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	13		0	29,601.00		0.00
TOTAL ACCOMODATIONS	89		0	100,530.00		11,499.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,383.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,602.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	52,761.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,433.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,034.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,789.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,503.00	0.00	MRI SERVICES	4,074.00	0.00
IV THERAPY	2,304.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	76,116.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,410.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,680.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,465.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,894.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,056.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,380.00	0.00	INJECTABLE DRUGS	89,208.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	38,710.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	136,671.00	5,786.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,231.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,849.00	0.00			
			TOTAL ANCILLARY	566,553.45	5,786.04
			TOTAL ACCOMODATIONS	100,530.00	11,499.00
			TOTAL CHARGES	667,083.45	17,285.04

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: 08/28/2018
Run Time: 23:46:52
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,474,467.39	ADJUSTMENTS	243,112.07
COVERED CHARGES	18,011,560.96	CONTRACTUAL ALLOW	15,007,212.67
NON-COVERD CHARGES	1,462,906.43	TOTAL MEDICAID LIAB	3,004,348.29
		LESS: COB	28,992.96
		LESS: COPAYMENT	9,115.97
		REIMBURSEMENT	2,966,239.36
		ALL OTHER	2,741,663.28
		FEE SCHEDULE-LAB	224,151.76
		INJECTABLE DRUGS	424.32
		TOTAL NUMBER OF CLAIMS	7,676

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
 5353 REYNOLDS ST
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,733,874.72	1,051.07	OTHER LAB	117,522.00	0.00
MED/SURG SUPPLY	207,733.31	217.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	3,215.00	530.20
RADIOLOGY-DIAGNOSTIC	723,008.40	63,307.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,617,456.00	326,912.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,199.00	5,696.04	FEE SCHEDULE LAB	1,952,616.75	36,306.00
EKG/ECG	84,168.00	1,837.00	MRI SERVICES	343,058.00	53,402.00
IV THERAPY	1,578,348.00	45,657.00	PROFESSIONAL FEES	0.00	1,423.00
OPERATING ROOM	2,317,592.36	206,160.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119,308.00	73,036.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	448,562.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	44,968.00	1,606.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,973,592.50	5,395.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	410,516.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,410.16	58,005.17
RADIOLOGY THERAPEUTIC	1,989,318.00	76,957.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,361.00	3,941.04	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,014.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,220.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,152.00	27.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	109,111.00	188,568.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	630,263.00	79,462.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	123,057.00	60,895.38			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,523.00	138,205.00			
AUDIOLOGY	0.00	10,682.00			
CARDIOLOGY	21,885.00	4,308.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	60,825.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	306,917.76	7,085.00			
			TOTAL ANCILLARY	18,011,560.96	1,462,906.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,011,560.96	1,462,906.43

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: 08/28/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	383,825.03	ADJUSTMENTS	0.00
COVERED CHARGES	312,474.17	CONTRACTUAL ALLOW	189,147.06
NON-COVERD CHARGES	71,350.86	TOTAL MEDICAID LIAB	123,327.11
		LESS: COB	123,132.10
		LESS: COPAYMENT	195.01
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 112

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,290.49	0.00	OTHER LAB	2,240.00	0.00
MED/SURG SUPPLY	6,267.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,493.00	1,541.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,299.00	25,770.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,097.00	862.00
EKG/ECG	835.00	0.00	MRI SERVICES	0.00	10,910.00
IV THERAPY	30,609.00	3,000.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	69,541.50	13,372.50	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	15,503.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,212.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,838.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,883.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,997.84	2,083.36
RADIOLOGY THERAPEUTIC	52,771.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,416.00	1,527.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,177.00	3,124.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,999.00	5,949.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,077.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,953.34	0.00			
			TOTAL ANCILLARY	312,474.17	71,350.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	312,474.17	71,350.86

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	378,570.35	ADJUSTMENTS	317.64
COVERED CHARGES	358,561.35	CONTRACTUAL ALLOW	342,786.27
NON-COVERD CHARGES	20,009.00	TOTAL MEDICAID LIAB	15,775.08
		LESS: COB	0.00
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	15,238.08
		TOTAL NUMBER OF CLAIMS	282

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,747.37	0.00	OTHER LAB	4,883.00	0.00
MED/SURG SUPPLY	1,592.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,174.00	5,175.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,600.00	7,896.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	47,615.00	689.00
EKG/ECG	3,173.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	41,319.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,142.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,683.00	374.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,295.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	109.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,945.00	5,875.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,642.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,641.00	0.00			
			TOTAL ANCILLARY	358,561.35	20,009.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	358,561.35	20,009.00

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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,585.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,585.00	CONTRACTUAL ALLOW	2,302.60
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	282.40
		LESS: COB	279.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56.00	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	700.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	750.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	2,585.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,585.00	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

CANDLER HOSPITAL
5353 REYNOLDS ST
SAVANNAH,GA 31405-6005

PROVIDER NUMBER
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,487,668.77	ADJUSTMENTS	11,084.46
COVERED CHARGES	1,393,415.77	CONTRACTUAL ALLOW	1,221,513.64
NON-COVERD CHARGES	94,253.00	TOTAL MEDICAID LIAB	171,902.13
		LESS: COB	3,764.94
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	168,035.19

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	634,662.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	36,484.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,860.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	435.00	FEE SCHEDULE LAB	4,580.00	18.00
EKG/ECG	334.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,868.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	151,925.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,266.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,987.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,580.88	1,406.00
RADIOLOGY THERAPEUTIC	73,964.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	269,346.00	92,394.00
LITHOTRIPSY	100,173.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,545.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,840.00	0.00			
			TOTAL ANCILLARY	1,393,415.77	94,253.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,393,415.77	94,253.00

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: 08/28/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,979,632.81	ADJUSTMENTS	80,470.21
COVERED CHARGES	1,934,265.81	CONTRACTUAL ALLOW	1,025,304.92
NON-COVERD CHARGES	45,367.00	TOTAL MEDICAID LIAB	908,960.89
		LESS: COB	7,352.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	901,608.51

TOTAL NUMBER OF ADMISSIONS 171

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	350		0	153,650.00		0.00
ROUTINE NURSERY	65		0	16,569.00		325.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	415		0	170,219.00		325.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	108		0	109,632.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	108		0	109,632.00		0.00
TOTAL ACCOMODATIONS	523		0	279,851.00		325.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,444.23	0.00	OTHER LAB	8,906.00	0.00
MED/SURG SUPPLY	28,838.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	266,697.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,109.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,348.00	32,729.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,270.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,625.00	0.00	MRI SERVICES	15,915.00	0.00
IV THERAPY	59,593.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,794.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	104,145.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	138,085.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,848.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	99,453.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,675.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,192.00	0.00	INJECTABLE DRUGS	350,785.90	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	9,184.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	524.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	72,662.24	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,651.00
OTHER IMAGING SERVICE	9,067.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,094.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,779.00	4,138.00			
AUDIOLOGY	141.00	0.00			
CARDIOLOGY	23,049.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,913.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,802.00	0.00			
			TOTAL ANCILLARY	1,654,414.81	45,042.00
			TOTAL ACCOMODATIONS	279,851.00	325.00
			TOTAL CHARGES	1,934,265.81	45,367.00

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016363019177	12/11/16 - 12/14/16	01/02/17	0.00	4,086.00	0.00	0.00	0.00
614	2017130035544	04/25/17 - 04/28/17	05/15/17	0.00	2,000.00	0.00	0.00	0.00
614	2017151047426	05/22/17 - 05/23/17	06/05/17	0.00	1,565.00	0.00	0.00	0.00
TOTAL				0.00	7,651.00	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: 08/28/2018
Run Time: 23:49:52
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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 07/01/16 THROUGH 06/30/17
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: 08/28/2018
Run Time: 23:49:52
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,373,063.93	ADJUSTMENTS	80,848.26
COVERED CHARGES	3,067,060.76	CONTRACTUAL ALLOW	2,023,335.29
NON-COVERD CHARGES	306,003.17	TOTAL MEDICAID LIAB	1,043,725.47
		LESS: COB	1,789.93
		LESS: COPAYMENT	1,441.60
		REIMBURSEMENT	1,040,493.94
		ALL OTHER	951,801.98
		FEE SCHEDULE-LAB	74,347.05
		INJECTABLE DRUGS	14,344.91

TOTAL NUMBER OF CLAIMS 2,043

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,192.40	14,045.64	OTHER LAB	23,033.00	0.00
MED/SURG SUPPLY	11,372.31	4,321.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	148,870.00	2,080.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	597,566.00	77,641.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,707.00	10,988.00	FEE SCHEDULE LAB	591,122.00	18,625.00
EKG/ECG	48,485.00	2,800.00	MRI SERVICES	63,090.00	11,789.00
IV THERAPY	248,432.00	16,984.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,560.50	9,063.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	790.00	192.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,584.00	4,973.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	94,271.50	879.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	649,685.00	2,227.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,057.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	125,627.05	68,281.03
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	1,623.00	6,242.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,703.00	3,504.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,257.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,017.00	4,827.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	345.00	345.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	93,459.00	34,173.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,965.00	11,052.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,484.00	971.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	67,763.00	0.00			
			TOTAL ANCILLARY	3,067,060.76	306,003.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,067,060.76	306,003.17

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,306.00	ADJUSTMENTS	0.00
COVERED CHARGES	58,766.00	CONTRACTUAL ALLOW	11,870.93
NON-COVERD CHARGES	18,540.00	TOTAL MEDICAID LIAB	46,895.07
		LESS: COB	46,877.07
		LESS: COPAYMENT	18.00
		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

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50.00	596.00	OTHER LAB	710.00	0.00
MED/SURG SUPPLY	312.00	25.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,907.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,280.00	5,142.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,680.00	685.00
EKG/ECG	875.00	700.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,346.00	2,886.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,825.00	1,452.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	58.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	447.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	314.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,580.00	208.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	303.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,359.00	1,400.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,505.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,975.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,252.00	1,471.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	963.00	0.00			
			TOTAL ANCILLARY	58,766.00	18,540.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,766.00	18,540.00

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

PROVIDER NUMBER
000000437A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	185,588.10	ADJUSTMENTS	155.61
COVERED CHARGES	182,325.80	CONTRACTUAL ALLOW	171,641.26
NON-COVERD CHARGES	3,262.30	TOTAL MEDICAID LIAB	10,684.54
		LESS: COB	27.30
		LESS: COPAYMENT	414.66
		REIMBURSEMENT	10,242.58
		TOTAL NUMBER OF CLAIMS	191

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189.00	15.00	OTHER LAB	810.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,852.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,140.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,070.00	480.00
EKG/ECG	1,925.00	0.00	MRI SERVICES	1,408.00	0.00
IV THERAPY	13,464.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	78,165.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,415.80	2,041.30
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	146.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,611.00	580.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	182,325.80	3,262.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	182,325.80	3,262.30

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

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

PROVIDER NUMBER
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,815.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,760.00	CONTRACTUAL ALLOW	1,484.26
NON-COVERD CHARGES	55.00	TOTAL MEDICAID LIAB	1,275.74
		LESS: COB	1,269.74
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	25.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	266.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,228.00	30.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,116.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,760.00	55.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,760.00	55.00

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 07/01/16 THROUGH 06/30/17
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: 08/28/2018
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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
 4 MEDICAL DR
 ELBERTON,GA 30635-1830

PROVIDER NUMBER 000000668A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	416,885.96	ADJUSTMENTS	17,914.80
COVERED CHARGES	409,386.96	CONTRACTUAL ALLOW	192,042.58
NON-COVERD CHARGES	7,499.00	TOTAL MEDICAID LIAB	217,344.38
		LESS: COB	2,451.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	214,892.95

TOTAL NUMBER OF ADMISSIONS 35

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	125		0	76,000.00		6,775.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	125		0	76,000.00		6,775.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	6,025.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,025.00		0.00
TOTAL ACCOMODATIONS	130		0	82,025.00		6,775.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,364.57	0.00	OTHER LAB	1,504.21	0.00
MED/SURG SUPPLY	33,770.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	60,188.96	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,525.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,504.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,276.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,100.00	0.00	MRI SERVICES	3,756.00	0.00
IV THERAPY	12,492.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,000.00	0.00	DURABLE MED. EQUIP.	0.00	168.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,812.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,910.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,721.92	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,975.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	272.00	0.00	INJECTABLE DRUGS	5,175.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,067.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,190.87	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,270.08	556.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,512.93	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	971.08	0.00			
			TOTAL ANCILLARY	327,361.96	724.00
			TOTAL ACCOMODATIONS	82,025.00	6,775.00
			TOTAL CHARGES	409,386.96	7,499.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,966.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,324.50	CONTRACTUAL ALLOW	470.32
NON-COVERD CHARGES	642.00	TOTAL MEDICAID LIAB	854.18
		LESS: COB	854.18
		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	608.00		642.00
ROUTINE NURSERY	0		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	608.00		642.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	608.00		642.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	560.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	156.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	716.50	0.00
			TOTAL ACCOMODATIONS	608.00	642.00
			TOTAL CHARGES	1,324.50	642.00

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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ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,221,805.87	ADJUSTMENTS	7,267.51
COVERED CHARGES	1,136,855.35	CONTRACTUAL ALLOW	832,543.10
NON-COVERD CHARGES	84,950.52	TOTAL MEDICAID LIAB	304,312.25
		LESS: COB	198.53
		LESS: COPAYMENT	954.00
		REIMBURSEMENT	303,159.72
		ALL OTHER	279,817.41
		FEE SCHEDULE-LAB	22,406.17
		INJECTABLE DRUGS	936.14

TOTAL NUMBER OF CLAIMS 835

Report : CLM-0804-0
 Process : CLMJ0800
 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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ELBERT MEMORIAL HOSPITAL
 4 MEDICAL DR
 ELBERTON,GA 30635-1830

PROVIDER NUMBER
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,277.41	15,173.81	OTHER LAB	12,768.07	0.00
MED/SURG SUPPLY	17,196.30	404.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	179.38	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,715.98	6,747.36	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	200,790.52	30,450.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,860.96	4,961.58	FEE SCHEDULE LAB	183,091.29	1,941.61
EKG/ECG	18,191.00	656.00	MRI SERVICES	54,287.92	3,649.78
IV THERAPY	61,731.81	856.31	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	115,000.00	6,500.00	DURABLE MED. EQUIP.	0.00	34.50
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,289.51	59.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,096.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	248,710.92	3,044.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,723.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,288.50	3,298.25
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	786.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,167.78	1,725.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	496.67	556.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,254.57	2,157.55			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,616.37	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,300.77	1,768.89			
			TOTAL ANCILLARY	1,136,855.35	84,950.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,136,855.35	84,950.52

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

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,799.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,064.50	CONTRACTUAL ALLOW	84.10
NON-COVERD CHARGES	1,735.00	TOTAL MEDICAID LIAB	980.40
		LESS: COB	977.40
		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

ELBERT MEMORIAL HOSPITAL
 4 MEDICAL DR
 ELBERTON,GA 30635-1830

PROVIDER NUMBER
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	179.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	269.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	173.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	167.00	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	60.00	56.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,064.50	1,735.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,064.50	1,735.00

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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ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,322.92	ADJUSTMENTS	164.82
COVERED CHARGES	99,296.15	CONTRACTUAL ALLOW	93,030.87
NON-COVERD CHARGES	6,026.77	TOTAL MEDICAID LIAB	6,265.28
		LESS: COB	0.00
		LESS: COPAYMENT	270.70
		REIMBURSEMENT	5,994.58
		TOTAL NUMBER OF CLAIMS	112

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,279.75	134.00	OTHER LAB	658.43	0.00
MED/SURG SUPPLY	104.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,796.63	592.53	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,118.98	5,172.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,759.92	108.24
EKG/ECG	820.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,992.45	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	224.76	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	49,380.29	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	576.00	20.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	254.17	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	330.77	0.00			
			TOTAL ANCILLARY	99,296.15	6,026.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	99,296.15	6,026.77

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DR
ELBERTON,GA 30635-1830

PROVIDER NUMBER
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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	07/01/16	THROUGH	06/30/17
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	07/01/16	THROUGH	06/30/17
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

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,716,481.46	ADJUSTMENTS	5,601,913.90
COVERED CHARGES	111,391,582.56	CONTRACTUAL ALLOW	76,995,640.58
NON-COVERD CHARGES	4,324,898.90	TOTAL MEDICAID LIAB	34,395,941.98
		LESS: COB	169,546.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,226,395.81

TOTAL NUMBER OF ADMISSIONS 1,578

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,526		41	11,821,512.00		907,313.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,526		41	11,821,512.00		907,313.00
SPECIAL CARE SERVICES						
CCU	311		0	1,819,350.00		0.00
ICU	4,446		0	18,702,655.00		260,356.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,757		0	20,522,005.00		260,356.00
TOTAL ACCOMODATIONS	13,283		41	32,343,517.00		1,167,669.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,287,968.28	130,282.06	OTHER LAB	514,043.00	7,262.00
MED/SURG SUPPLY	4,820,500.14	178,437.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,984,517.00	370,166.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,553,858.08	24,223.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,458,297.00	23,148.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	778,525.20	15,512.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	330,898.00	4,242.00	MRI SERVICES	1,667,427.00	8,530.00
IV THERAPY	186.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,702,009.00	313,716.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,928,693.00	66,347.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,292,387.00	70,676.00	AMBULANCE	0.00	0.00
GI SERVICES	492,096.00	1,789.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,605,068.00	6,324.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	885,181.00	13,896.00	DRUG-SPECIFIC/HOME IV	0.00	329,531.37
LABORATORY PATHOLOGIC	713,912.00	18,648.00	INJECTABLE DRUGS	12,861,380.72	338,727.25
RADIOLOGY THERAPEUTIC	118,448.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	614,861.41	23,398.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	235,052.41	4,164.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	785,253.00	160,075.00	PATIENT CONVENIENCE	0.00	417.50
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,643.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	274.00	0.00	IMPL DEV CHARGE PATIENTS	2,984,920.32	201,087.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	230,908.00
OTHER IMAGING SERVICE	233,684.00	163,765.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,433,237.00	220,104.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,963.00	73,434.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,883,996.00	22,239.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,263,214.00	0.00			
ORGAN ACQUISITION	1,512,454.00	136,181.00			
TREATMENT/OBSERV. RM	39,119.00	0.00			
			TOTAL ANCILLARY	79,048,065.56	3,157,229.90
			TOTAL ACCOMODATIONS	32,343,517.00	1,167,669.00
			TOTAL CHARGES	111,391,582.56	4,324,898.90

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016320068695	10/28/16 - 11/04/16	11/21/16	0.00	4,265.00	0.00	0.00	0.00
615	2016325000719	11/09/16 - 11/15/16	11/28/16	0.00	2,569.00	0.00	0.00	0.00
614	2016327036911	09/18/16 - 10/15/16	11/28/16	0.00	4,265.00	0.00	0.00	0.00
615	2216356008642	11/21/16 - 11/25/16	12/26/16	0.00	4,265.00	0.00	0.00	0.00
615	2216363007717	11/13/16 - 11/18/16	01/02/17	0.00	8,530.00	0.00	0.00	0.00
615	2016363043181	12/05/16 - 12/22/16	01/02/17	0.00	2,569.00	0.00	0.00	0.00
615	2217005002164	10/30/16 - 11/03/16	01/09/17	0.00	8,530.00	0.00	0.00	0.00
614	2317009000312	09/01/16 - 09/09/16	02/13/17	0.00	4,265.00	0.00	3,686.24	0.00
615	2017011073428	12/01/16 - 12/05/16	01/16/17	0.00	8,530.00	0.00	0.00	0.00
615	2017083073143	03/02/17 - 03/19/17	04/03/17	0.00	8,530.00	0.00	0.00	0.00
615	2017090074792	03/09/17 - 03/17/17	04/10/17	0.00	2,569.00	0.00	0.00	0.00
615	2017103079317	01/31/17 - 02/01/17	04/17/17	0.00	8,530.00	0.00	0.00	0.00
615	2017120005047	04/19/17 - 04/25/17	05/08/17	0.00	2,569.00	0.00	0.00	0.00
615	2017143072819	04/08/17 - 05/18/17	05/29/17	0.00	4,265.00	0.00	0.00	0.00
615	2017178057621	06/14/17 - 06/22/17	07/03/17	0.00	8,530.00	0.00	0.00	0.00
615	2317191000164	04/27/17 - 05/01/17	07/24/17	0.00	8,530.00	0.00	1,868.28	0.00
615	2017191025926	06/12/17 - 07/02/17	07/17/17	0.00	12,795.00	0.00	0.00	0.00
615	2217195014791	12/26/16 - 01/25/17	07/17/17	0.00	4,265.00	0.00	0.00	0.00
614	2317199000174	05/01/17 - 05/05/17	08/14/17	0.00	8,530.00	0.00	970.73	0.00
614	2317200000315	11/29/16 - 12/04/16	08/21/17	0.00	4,265.00	0.00	907.92	0.00
614	2317207000321	12/20/16 - 12/29/16	09/04/17	0.00	8,530.00	0.00	1,571.26	0.00
614	2317213000127	02/15/17 - 02/25/17	09/11/17	0.00	4,265.00	0.00	7,828.53	0.00
615	5217221000141	10/10/16 - 11/25/16	04/02/18	0.00	4,265.00	0.00	0.00	0.00
615	5217234000025	01/07/17 - 02/05/17	04/02/18	0.00	2,569.00	0.00	0.00	0.00
614	2317235000118	09/10/16 - 09/23/16	10/02/17	0.00	4,265.00	0.00	0.00	0.00
618	2217241002296	02/16/17 - 04/30/17	09/04/17	0.00	3,067.00	0.00	0.00	0.00
615	2317244000144	03/09/17 - 04/03/17	10/02/17	0.00	8,530.00	0.00	0.00	0.00
614	2017256105319	05/09/17 - 06/05/17	09/18/17	0.00	8,530.00	0.00	0.00	0.00
615	2017264043501	08/18/17 - 09/13/17	09/25/17	0.00	2,569.00	0.00	0.00	0.00
614	2317272000037	03/03/17 - 03/14/17	10/23/17	0.00	4,265.00	0.00	3,001.63	0.00
614	5917290001365	08/21/17 - 09/05/17	10/23/17	0.00	2,569.00	0.00	0.00	0.00
615	2317320000280	02/07/17 - 03/09/17	12/11/17	0.00	4,265.00	0.00	0.00	0.00
615	2317349000198	07/03/17 - 07/08/17	01/15/18	0.00	8,530.00	0.00	0.00	0.00
614	2318011000325	08/18/17 - 09/05/17	02/05/18	0.00	8,530.00	0.00	0.00	0.00
615	2318024000127	04/06/17 - 04/09/17	02/12/18	0.00	8,530.00	0.00	2,176.93	0.00
614	2218037012128	11/06/16 - 11/25/16	02/12/18	0.00	4,265.00	0.00	0.00	0.00
614	2318094000262	08/21/17 - 09/09/17	04/16/18	0.00	4,265.00	0.00	7,547.23	0.00
614	5218100000023	08/26/17 - 09/16/17	04/16/18	0.00	4,265.00	0.00	0.00	0.00
614	2218109002600	04/13/17 - 04/23/17	04/23/18	0.00	2,569.00	0.00	0.00	0.00
614	2318158000375	05/05/17 - 05/26/17	07/02/18	0.00	2,569.00	0.00	1,969.12	0.00
614	2018173066856	07/12/17 - 07/16/17	07/02/18	0.00	8,530.00	0.00	0.00	0.00

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

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

Run Date: 08/28/2018
Run Time: 23:36:00
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

TOTAL	0.00	230,908.00	0.00	31,527.87	0.00
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Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

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

Run Date: 08/28/2018
 Run Time: 23:36:34
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,454,993.16	ADJUSTMENTS	0.00
COVERED CHARGES	1,428,812.10	CONTRACTUAL ALLOW	608,762.37
NON-COVERD CHARGES	26,181.06	TOTAL MEDICAID LIAB	820,049.73
		LESS: COB	820,049.73
		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	136		0	188,860.00		9,836.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	136		0	188,860.00		9,836.00
SPECIAL CARE SERVICES						
CCU	5		0	29,250.00		0.00
ICU	57		0	204,794.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	62		0	234,044.00		0.00
TOTAL ACCOMODATIONS	198		0	422,904.00		9,836.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,726.39	203.14	OTHER LAB	972.00	0.00
MED/SURG SUPPLY	93,265.00	182.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	195,606.00	6,834.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,347.00	280.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,291.00	2,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,281.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,942.00	292.00	MRI SERVICES	45,395.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	132,244.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66,981.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,225.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,291.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,539.00	1,500.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,927.00	0.00	INJECTABLE DRUGS	137,252.68	874.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,676.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	878.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,217.00	1,154.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	64.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,744.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,636.00	665.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,804.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,454.00	177.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	37,467.00	1,655.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,365.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,438.00	0.00			
			TOTAL ANCILLARY	1,005,908.10	16,345.06
			TOTAL ACCOMODATIONS	422,904.00	9,836.00
			TOTAL CHARGES	1,428,812.10	26,181.06

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: 08/28/2018
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,537,843.49	ADJUSTMENTS	520,836.77
COVERED CHARGES	18,188,168.15	CONTRACTUAL ALLOW	14,894,301.75
NON-COVERD CHARGES	7,349,675.34	TOTAL MEDICAID LIAB	3,293,866.40
		LESS: COB	8,496.35
		LESS: COPAYMENT	9,352.91
		REIMBURSEMENT	3,276,017.14
		ALL OTHER	2,439,577.01
		FEE SCHEDULE-LAB	774,624.87
		INJECTABLE DRUGS	61,815.26
		TOTAL NUMBER OF CLAIMS	11,207

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	190,698.77	413,863.34	OTHER LAB	122,946.00	461.00
MED/SURG SUPPLY	579,546.12	318.00	RECREATIONAL THERAPY	21,708.00	0.00
LABORATORY-GENERAL	0.00	583.00	EDUCATION & TRAINING	56.00	1,624.00
RADIOLOGY-DIAGNOSTIC	556,431.00	521,582.00	OTHER THERAPEUTIC SVC	123,012.00	195,810.00
CT SCAN	1,678,706.00	978,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	7,171.15	FEE SCHEDULE LAB	4,587,131.58	680,041.00
EKG/ECG	148,336.00	3,942.00	MRI SERVICES	1,731,783.00	958,149.00
IV THERAPY	1,688.00	122.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,809,476.00	579,135.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,410.00	4,271.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	326,082.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	132,093.00	97,756.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,728,067.00	52,010.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	300,317.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,617.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	518,547.36	354,339.33
RADIOLOGY THERAPEUTIC	417,141.00	307,255.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,954.02	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	100,879.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,881.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	274.00	IMPL DEV CHARGE PATIENTS	218,950.32	725,106.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	69,012.00
OTHER IMAGING SERVICE	730,076.00	489,091.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72,019.00	3,917.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	170,681.00	305,189.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	772,251.00	445,138.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,790.00	2,115.00			
ORGAN ACQUISITION	0.00	39,766.50			
TREATMENT/OBSERV. RM	189,225.00	3,725.00			
			TOTAL ANCILLARY	18,188,168.15	7,349,600.34
			TOTAL ACCOMODATIONS	0.00	75.00
			TOTAL CHARGES	18,188,168.15	7,349,675.34

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

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

Run Date: 08/28/2018
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016264063096	09/09/16 - 09/09/16	09/26/16	0.00	2,569.00	0.00	0.00	0.00
615	2016264063096	09/09/16 - 09/09/16	09/26/16	0.00	2,569.00	0.00	0.00	0.00
615	2016281066302	09/28/16 - 09/28/16	10/17/16	0.00	4,265.00	0.00	0.00	0.00
615	2016281066302	09/28/16 - 09/28/16	10/17/16	0.00	4,265.00	0.00	0.00	0.00
615	2016308106971	10/28/16 - 10/28/16	11/07/16	0.00	2,569.00	0.00	0.00	0.00
615	2016354027602	12/13/16 - 12/13/16	12/26/16	0.00	4,265.00	0.00	0.00	0.00
615	2016354027602	12/13/16 - 12/13/16	12/26/16	0.00	4,265.00	0.00	0.00	0.00
615	2016364000175	12/16/16 - 12/16/16	01/02/17	0.00	4,265.00	0.00	0.00	0.00
615	2016364000175	12/16/16 - 12/16/16	01/02/17	0.00	4,265.00	0.00	0.00	0.00
615	2017039067648	01/23/17 - 01/23/17	02/13/17	0.00	2,569.00	0.00	0.00	0.00
615	2017093052957	03/27/17 - 03/27/17	04/10/17	0.00	4,265.00	0.00	0.00	0.00
615	2017117092868	04/14/17 - 04/14/17	05/01/17	0.00	4,265.00	0.00	0.00	0.00
615	2017117092868	04/14/17 - 04/14/17	05/01/17	0.00	4,265.00	0.00	0.00	0.00
615	2017120005108	04/24/17 - 04/24/17	05/08/17	0.00	4,265.00	0.00	0.00	0.00
615	2017123078365	04/25/17 - 04/25/17	05/08/17	0.00	4,265.00	0.00	0.00	0.00
615	5917200000848	06/06/17 - 06/06/17	07/24/17	0.00	2,569.00	0.00	0.00	0.00
615	5917240000329	08/02/17 - 08/02/17	09/04/17	0.00	4,265.00	0.00	0.00	0.00
615	5917240000329	08/02/17 - 08/02/17	09/04/17	0.00	4,265.00	0.00	0.00	0.00
8622	5917257002809	06/23/17 - 06/23/17	09/18/17	0.00	52.00	0.00	0.00	0.00
8124	2218173010668	07/17/17 - 07/17/17	06/25/18	0.00	670.00	0.00	731.01	0.00
TOTAL				0.00	69,012.00	0.00	731.01	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 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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,036,655.05	ADJUSTMENTS	0.00
COVERED CHARGES	416,380.82	CONTRACTUAL ALLOW	-39,161.99
NON-COVERD CHARGES	620,274.23	TOTAL MEDICAID LIAB	455,542.81
		LESS: COB	455,241.79
		LESS: COPAYMENT	301.02
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 161

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,581.16	19,970.19	OTHER LAB	2,220.00	0.00
MED/SURG SUPPLY	30,263.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,558.00	44,633.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,112.00	86,364.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	542.00	FEE SCHEDULE LAB	96,965.00	21,315.00
EKG/ECG	3,577.00	0.00	MRI SERVICES	8,530.00	120,849.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,980.00	71,609.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,020.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,873.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,502.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,429.00	344.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,661.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,650.66	12,155.04
RADIOLOGY THERAPEUTIC	1,853.00	21,834.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	464.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,165.00	77,444.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,530.00
OTHER IMAGING SERVICE	5,810.00	35,372.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,481.00	2,954.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,950.00	92,970.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,702.00	423.00			
			TOTAL ANCILLARY	416,380.82	620,274.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	416,380.82	620,274.23

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

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

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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,621.77	ADJUSTMENTS	96.23
COVERED CHARGES	107,083.51	CONTRACTUAL ALLOW	104,342.45
NON-COVERD CHARGES	9,538.26	TOTAL MEDICAID LIAB	2,741.06
		LESS: COB	0.00
		LESS: COPAYMENT	120.65
		REIMBURSEMENT	2,620.41
		TOTAL NUMBER OF CLAIMS	49

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,736.82	31.59	OTHER LAB	891.00	0.00
MED/SURG SUPPLY	1,735.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,803.00	169.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,407.00	3,905.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,770.00	410.00
EKG/ECG	2,190.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,159.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,694.00	546.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	323.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,943.69	1,847.67
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	142.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,143.00	752.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,441.00	222.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,655.00			
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	0.00	0.00			
			TOTAL ANCILLARY	107,083.51	9,538.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,083.51	9,538.26

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,330.27	ADJUSTMENTS	0.00
COVERED CHARGES	6,761.27	CONTRACTUAL ALLOW	2,859.60
NON-COVERD CHARGES	2,569.00	TOTAL MEDICAID LIAB	3,901.67
		LESS: COB	3,883.67
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 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	891.00	0.00
MED/SURG SUPPLY	272.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	433.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,796.00	0.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,113.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	110.27	105.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,761.27	2,569.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,761.27	2,569.00

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 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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,235,210.82	ADJUSTMENTS	77,367.00
COVERED CHARGES	1,038,198.27	CONTRACTUAL ALLOW	876,923.27
NON-COVERD CHARGES	197,012.55	TOTAL MEDICAID LIAB	161,275.00
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	161,182.00

TOTAL NUMBER OF CLAIMS 25

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,342.38	3,200.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	43,015.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,764.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,616.00	67,344.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	680.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	772.00	FEE SCHEDULE LAB	19,090.00	738.00
EKG/ECG	292.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	322,588.00	57,706.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	657.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,095.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,321.00	4,148.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,309.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,453.64	6,093.60
RADIOLOGY THERAPEUTIC	1,655.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	655.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	64.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	321,192.25	29,224.00
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.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,481.00	11,284.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	100,470.00	7,489.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,944.00	0.00			
			TOTAL ANCILLARY	1,038,198.27	191,162.55
			TOTAL ACCOMODATIONS	0.00	5,850.00
			TOTAL CHARGES	1,038,198.27	197,012.55

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	09/01/16	THROUGH	08/31/17
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: 08/28/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL
 1821 CLIFTON RD NE
 ATLANTA,GA 30329-4021

PROVIDER NUMBER
 000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,096,865.49	ADJUSTMENTS	117,841.99
COVERED CHARGES	2,808,372.16	CONTRACTUAL ALLOW	578,485.99
NON-COVERD CHARGES	1,288,493.33	TOTAL MEDICAID LIAB	2,229,886.17
		LESS: COB	833.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,229,052.65

TOTAL NUMBER OF ADMISSIONS 211

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,468		0	2,072,837.00		1,280,377.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,468		0	2,072,837.00		1,280,377.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,468		0	2,072,837.00		1,280,377.00

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
 1821 CLIFTON RD NE
 ATLANTA,GA 30329-4021

PROVIDER NUMBER
 000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,224.80	0.00	OTHER LAB	891.00	0.00
MED/SURG SUPPLY	376.00	25.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	362,233.00	2,762.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,498.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,315.00	1,441.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,022.00	0.00	MRI SERVICES	4,265.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,618.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	236,942.36	3,888.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	691.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	60,298.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,907.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,000.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,254.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	735,535.16	8,116.33
			TOTAL ACCOMODATIONS	2,072,837.00	1,280,377.00
			TOTAL CHARGES	2,808,372.16	1,288,493.33

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
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/16 THROUGH 08/31/17
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: 08/28/2018
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EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	281,139.98	ADJUSTMENTS	0.00
COVERED CHARGES	280,866.69	CONTRACTUAL ALLOW	213,372.53
NON-COVERD CHARGES	273.29	TOTAL MEDICAID LIAB	67,494.16
		LESS: COB	0.00
		LESS: COPAYMENT	234.32
		REIMBURSEMENT	67,259.84
		ALL OTHER	66,567.87
		FEE SCHEDULE-LAB	670.44
		INJECTABLE DRUGS	21.53

TOTAL NUMBER OF CLAIMS 80

EMORY UNIVERSITY HOSPITAL
 1821 CLIFTON RD NE
 ATLANTA,GA 30329-4021

PROVIDER NUMBER
 000000712B

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 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	4,348.00	246.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	127.69	27.29
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	276,391.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	280,866.69	273.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	280,866.69	273.29

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
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: 08/28/2018
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EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
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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EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
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

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
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: 08/28/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL
1821 CLIFTON RD NE
ATLANTA,GA 30329-4021

PROVIDER NUMBER
000000712B

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	138,761,645.45	ADJUSTMENTS	6,153,218.11
COVERED CHARGES	135,197,348.94	CONTRACTUAL ALLOW	100,371,869.68
NON-COVERD CHARGES	3,564,296.51	TOTAL MEDICAID LIAB	34,825,479.26
		LESS: COB	308,704.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,516,774.41

TOTAL NUMBER OF ADMISSIONS 2,490

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,165		4	9,525,841.00		1,447,559.00
ROUTINE NURSERY	755		0	864,980.00		385,725.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		18.01
TOTAL ROUTINE	12,920		4	10,390,821.00		1,833,302.01
SPECIAL CARE SERVICES						
CCU	195		0	353,576.00		3,664.00
ICU	1,822		0	3,837,856.00		45,654.00
NICU	595		0	2,312,765.00		0.00
PED ICU	752		0	2,706,196.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	282		0	967,542.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,646		0	10,177,935.00		49,318.00
TOTAL ACCOMODATIONS	16,566		4	20,568,756.00		1,882,620.01

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,604,583.62	242,799.98	OTHER LAB	533,774.00	11,668.00
MED/SURG SUPPLY	12,698,708.00	135,398.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,386,150.19	307,135.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,714,360.00	19,669.00	OTHER THERAPEUTIC SVC	0.00	46,152.00
CT SCAN	3,683,067.00	121,760.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	771,457.58	45,282.10	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	261,519.00	1,264.00	MRI SERVICES	1,163,097.00	0.00
IV THERAPY	818,419.00	9,083.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,908,611.00	57,465.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	332,988.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,951,148.00	102,085.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,090,724.00	10,914.00	AMBULANCE	0.00	0.00
GI SERVICES	374,411.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,739,974.00	3,775.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	717,295.00	1,454.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	879,648.40	1,338.00	INJECTABLE DRUGS	7,317,112.42	60,428.30
RADIOLOGY THERAPEUTIC	183,062.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	399,760.64	2,598.07	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	297,039.09	1,458.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	340,361.00	60,823.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	314.00	3,472.00	TRAUMA RESPONSE	0.00	193,170.00
PSYCHIATRIC SERVICES	25,310.00	0.00	IMPL DEV CHARGE PATIENTS	9,195,388.00	53,217.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	496,927.00	22,216.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,394,114.00	91,860.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	128,141.00	1,602.00			
AUDIOLOGY	686.00	0.00			
CARDIOLOGY	4,667,000.00	73,590.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,270,561.00	0.00			
ORGAN ACQUISITION	124,961.00	0.00			
TREATMENT/OBSERV. RM	157,921.00	0.00			
			TOTAL ANCILLARY	114,628,592.94	1,681,676.50
			TOTAL ACCOMODATIONS	20,568,756.00	1,882,620.01
			TOTAL CHARGES	135,197,348.94	3,564,296.51

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,156,637.36	ADJUSTMENTS	0.00
COVERED CHARGES	3,133,491.36	CONTRACTUAL ALLOW	1,710,742.04
NON-COVERD CHARGES	23,146.00	TOTAL MEDICAID LIAB	1,422,749.32
		LESS: COB	1,422,749.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	95		0	75,240.00		6,705.00
ROUTINE NURSERY	2		0	1,584.00		1,850.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	97		0	76,824.00		8,555.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	38		0	78,496.00		0.00
NICU	108		0	423,683.00		0.00
PED ICU	19		0	69,065.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	3		0	10,293.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	168		0	581,537.00		0.00
TOTAL ACCOMODATIONS	265		0	658,361.00		8,555.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,047.76	0.00	OTHER LAB	44,008.00	0.00
MED/SURG SUPPLY	335,840.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	269,974.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,513.00	0.00	OTHER THERAPEUTIC SVC	0.00	384.00
CT SCAN	37,106.00	4,715.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,727.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,896.00	0.00	MRI SERVICES	5,932.00	0.00
IV THERAPY	10,018.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	335,326.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,086.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	379,007.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	116,823.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,536.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,717.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	28,875.00	0.00	INJECTABLE DRUGS	46,941.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,437.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,293.09	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,030.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,783.00	TRAUMA RESPONSE	0.00	7,709.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	226,981.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,145.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,946.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	891.00	0.00			
CARDIOLOGY	47,231.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	74,679.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	124.00	0.00			
			TOTAL ANCILLARY	2,475,130.36	14,591.00
			TOTAL ACCOMODATIONS	658,361.00	8,555.00
			TOTAL CHARGES	3,133,491.36	23,146.00

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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,992,443.08	ADJUSTMENTS	2,164,876.94
COVERED CHARGES	62,823,564.21	CONTRACTUAL ALLOW	51,102,182.23
NON-COVERD CHARGES	6,168,878.87	TOTAL MEDICAID LIAB	11,721,381.98
		LESS: COB	51,814.22
		LESS: COPAYMENT	53,350.62
		REIMBURSEMENT	11,616,217.14
		ALL OTHER	9,263,674.06
		FEE SCHEDULE-LAB	813,408.59
		INJECTABLE DRUGS	1,539,134.49

TOTAL NUMBER OF CLAIMS 33,556

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

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

Run Date: 08/28/2018
 Run Time: 23:58:02
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,802,721.70	6,575.98	OTHER LAB	1,074,936.00	34,429.50
MED/SURG SUPPLY	1,946,742.00	4,065.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	688.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,902,647.00	23,391.00	OTHER THERAPEUTIC SVC	0.00	5,696.00
CT SCAN	3,096,121.00	724,690.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	97,882.33	33,002.05	FEE SCHEDULE LAB	8,717,774.66	183,621.83
EKG/ECG	272,727.00	632.00	MRI SERVICES	1,962,297.00	316,613.00
IV THERAPY	1,316,554.86	6,834.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,359,212.25	689,910.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,270.00	0.00	REHAB THERAPY	0.00	440.00
RESPIRATORY SERVICES	738,147.00	21,108.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,890,042.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	565,091.80	102,321.92	CAST ROOM	19,982.00	1,262.00
EMERGENCY ROOM	4,915,883.00	16,483.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,261,504.00	0.00	HOSPICE SERVICES	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RADIOLOGY THERAPEUTIC	2,313,576.00	56,352.00	PATIENT CONVENIENCE	0.00	0.00
OCCUPATIONAL THERAPY	24,594.00	23,759.84	O/P SPECIAL RESIDENCE	0.00	0.00
SPEECH PATHOLOGY	40,895.00	16,131.36	TRAUMA RESPONSE	0.00	234,180.00
RENAL DIALYSIS	0.00	41,590.00	IMPL DEV CHARGE PATIENTS	654,174.00	2,507.00
OUTPATIENT SERVICES	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,014.52
CLINIC SERVICES	5,717,907.00	165,664.00			
PSYCHIATRIC SERVICES	78,465.00	33,112.00			
LITHOTRIPSY	0.00	0.00			
OTHER IMAGING SERVICE	966,235.00	259,726.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	603,069.00	848.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	407,851.00	27,721.00			
AUDIOLOGY	10,389.00	10,849.00			
CARDIOLOGY	870,003.00	460,046.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	198.00			
E E G	587,431.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	803,052.00	26,990.00			
			TOTAL ANCILLARY	62,823,564.21	6,168,878.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	62,823,564.21	6,168,878.87

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016342059139	11/11/16 - 11/11/16	12/12/16	0.00	2,295.00	0.00	0.00	0.00
626	5917047001510	12/21/16 - 12/21/16	02/20/17	0.00	2,719.52	0.00	0.00	0.00
TOTAL				0.00	5,014.52	0.00	0.00	0.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,663.28	1,762.43	OTHER LAB	29,052.00	3,248.00
MED/SURG SUPPLY	53,041.00	12,927.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,388.00	2,126.00	OTHER THERAPEUTIC SVC	0.00	128.00
CT SCAN	23,404.00	48,067.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,488.00	FEE SCHEDULE LAB	127,347.00	5,534.04
EKG/ECG	7,409.00	0.00	MRI SERVICES	10,337.00	63,996.00
IV THERAPY	15,344.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	136,591.62	102,237.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,469.00	977.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,263.00	109.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	16,658.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	84,856.00	1,109.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,725.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,561.38	129,153.05
RADIOLOGY THERAPEUTIC	19,903.00	3,131.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,613.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	53,516.00	4,605.00	TRAUMA RESPONSE	0.00	8,984.00
PSYCHIATRIC SERVICES	1,466.00	455.00	IMPL DEV CHARGE PATIENTS	8,398.00	137,666.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,634.00	24,288.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,283.00	13,333.00			
AUDIOLOGY	983.00	686.00			
CARDIOLOGY	27,546.00	81,114.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	44,067.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,616.00	2,310.00			
			TOTAL ANCILLARY	913,863.28	670,704.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	913,863.28	670,704.90

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,608,666.23	ADJUSTMENTS	3,495.22
COVERED CHARGES	2,472,307.27	CONTRACTUAL ALLOW	2,373,257.27
NON-COVERD CHARGES	136,358.96	TOTAL MEDICAID LIAB	99,050.00
		LESS: COB	121.96
		LESS: COPAYMENT	3,708.00
		REIMBURSEMENT	95,220.04
		TOTAL NUMBER OF CLAIMS	1,981

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,622.97	340.85	OTHER LAB	39,130.00	74.00
MED/SURG SUPPLY	5,284.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	122,198.00	522.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	178,678.00	61,798.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	361.00	0.00	FEE SCHEDULE LAB	377,581.32	3,776.00
EKG/ECG	21,014.00	0.00	MRI SERVICES	19,884.00	20,186.00
IV THERAPY	110,589.00	217.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,008.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,184.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	811.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,610.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,386,165.00	3,457.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,436.98	650.08
RADIOLOGY THERAPEUTIC	2,180.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	325.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	430.03	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	8,419.00	323.00	TRAUMA RESPONSE	0.00	11,217.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	844.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,939.00	29,372.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	708.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,996.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,199.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,136.00	0.00			
			TOTAL ANCILLARY	2,472,307.27	136,358.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,472,307.27	136,358.96

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,994.46	700.00	OTHER LAB	2,052.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,159.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	11,319.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,337.00	174.00
EKG/ECG	158.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,069.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,294.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	327.00	0.00	TRAUMA RESPONSE	0.00	4,492.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	658.00	5,475.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	666.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,070.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	960.00	0.00			
			TOTAL ANCILLARY	66,078.46	22,826.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,078.46	22,826.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,059,358.76	ADJUSTMENTS	492,895.05
COVERED CHARGES	13,246,453.70	CONTRACTUAL ALLOW	11,588,817.05
NON-COVERD CHARGES	812,905.06	TOTAL MEDICAID LIAB	1,657,636.65
		LESS: COB	0.00
		LESS: COPAYMENT	800.22
		REIMBURSEMENT	1,656,836.43

TOTAL NUMBER OF CLAIMS 279

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	553,917.91	0.00	OTHER LAB	6,243.00	3,923.00
MED/SURG SUPPLY	1,019,340.00	11,339.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132,169.00	15,431.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,214.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,083.00	3,705.00	FEE SCHEDULE LAB	190,085.00	419.00
EKG/ECG	2,733.00	0.00	MRI SERVICES	0.00	9,495.00
IV THERAPY	30,089.00	128.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	937,759.43	163,086.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,915.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	286,615.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,678.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,632.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	90,659.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,714,069.70	67,808.99
RADIOLOGY THERAPEUTIC	397,963.00	14,833.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,875.16	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	430.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	991.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,123.00	1,906.00	TRAUMA RESPONSE	0.00	6,725.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,593,109.00	7,815.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,926.00	2,328.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,960.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,658.00	7,623.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,071,534.66	490,741.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,130.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	40,848.00	1,302.00			
			TOTAL ANCILLARY	13,246,453.70	812,905.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,246,453.70	812,905.06

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

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

Run Date: 08/29/2018
Run Time: 00:00:49
Page: 16

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	07/01/16	THROUGH	06/30/17
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: 08/28/2018
 Run Time: 23:27:54
 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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,032,748.56	ADJUSTMENTS	2,792,165.24
COVERED CHARGES	46,552,699.09	CONTRACTUAL ALLOW	37,246,544.64
NON-COVERD CHARGES	2,480,049.47	TOTAL MEDICAID LIAB	9,306,154.45
		LESS: COB	84,147.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,222,006.93

TOTAL NUMBER OF ADMISSIONS 1,136

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,030		0	4,553,494.00		945,888.00
ROUTINE NURSERY	1,443		0	2,675,197.00		367,554.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,473		0	7,228,691.00		1,313,442.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	610		0	2,392,850.00		58,674.00
NICU	121		0	745,723.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	731		0	3,138,573.00		58,674.00
TOTAL ACCOMODATIONS	6,204		0	10,367,264.00		1,372,116.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,653,736.02	186,124.50	OTHER LAB	95,967.00	0.00
MED/SURG SUPPLY	1,900,668.62	51,136.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,457,878.45	99,097.47	EDUCATION & TRAINING	1,900.00	158.00
RADIOLOGY-DIAGNOSTIC	593,188.00	2,998.00	OTHER THERAPEUTIC SVC	0.00	19,435.00
CT SCAN	1,147,507.00	10,974.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	435,399.00	28,588.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	171,752.00	350.00	MRI SERVICES	459,193.00	0.00
IV THERAPY	84,623.00	186.00	PROFESSIONAL FEES	0.00	5,700.00
OPERATING ROOM	3,232,042.00	54,434.00	DURABLE MED. EQUIP.	0.00	1,290.00
LABOR/DELIVERY ROOM	1,300,559.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,987,947.00	40,077.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	533,171.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	22,491.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	906,229.00	1,201.00	SPECIAL SERVICES	0.00	98,416.00
RECOVERY ROOM	350,528.00	860.00	DRUG-SPECIFIC/HOME IV	0.00	83,016.00
LABORATORY PATHOLOGIC	403,771.00	0.00	INJECTABLE DRUGS	7,920,257.00	41,504.50
RADIOLOGY THERAPEUTIC	570,676.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	271,585.00	15,381.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	123,737.00	3,104.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	301,729.00	54,053.00	PATIENT CONVENIENCE	0.00	184.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120.00	709.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,263,076.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	276,779.00	162,688.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	331,740.00	124,680.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	111,045.00	20,511.00			
AUDIOLOGY	140,266.00	0.00			
CARDIOLOGY	1,085,708.00	1,078.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,142.00	0.00			
ORGAN ACQUISITION	17,787.00	0.00			
TREATMENT/OBSERV. RM	21,238.00	0.00			
			TOTAL ANCILLARY	36,185,435.09	1,107,933.47
			TOTAL ACCOMODATIONS	10,367,264.00	1,372,116.00
			TOTAL CHARGES	46,552,699.09	2,480,049.47

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,633,873.70	ADJUSTMENTS	0.00
COVERED CHARGES	1,591,498.70	CONTRACTUAL ALLOW	1,224,460.56
NON-COVERD CHARGES	42,375.00	TOTAL MEDICAID LIAB	367,038.14
		LESS: COB	367,038.14
		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	46		0	53,797.00		6,075.00
ROUTINE NURSERY	89		0	309,098.00		22,224.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	135		0	362,895.00		28,299.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	50		0	308,150.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	50		0	308,150.00		0.00
TOTAL ACCOMODATIONS	185		0	671,045.00		28,299.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,050.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	51,540.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	123,027.20	0.00	EDUCATION & TRAINING	83.00	0.00
RADIOLOGY-DIAGNOSTIC	22,260.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,870.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,050.00	0.00	MRI SERVICES	20,100.00	0.00
IV THERAPY	507.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,713.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	29,255.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	211,580.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,704.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,491.00	0.00	SPECIAL SERVICES	0.00	4,646.00
RECOVERY ROOM	9,131.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,058.00	0.00	INJECTABLE DRUGS	96,099.00	0.00
RADIOLOGY THERAPEUTIC	92,566.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	15,617.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,248.00	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	12,610.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,735.00	7,010.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,850.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,420.00			
AUDIOLOGY	2,987.00	0.00			
CARDIOLOGY	9,322.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	920,453.70	14,076.00
			TOTAL ACCOMODATIONS	671,045.00	28,299.00
			TOTAL CHARGES	1,591,498.70	42,375.00

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: 08/28/2018
Run Time: 23:28:28
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,727,924.29	ADJUSTMENTS	661,656.95
COVERED CHARGES	16,561,500.39	CONTRACTUAL ALLOW	14,167,681.59
NON-COVERD CHARGES	1,166,423.90	TOTAL MEDICAID LIAB	2,393,818.80
		LESS: COB	1,992.86
		LESS: COPAYMENT	6,712.15
		REIMBURSEMENT	2,385,113.79
		ALL OTHER	2,090,203.25
		FEE SCHEDULE-LAB	116,485.35
		INJECTABLE DRUGS	178,425.19

TOTAL NUMBER OF CLAIMS 3,451

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	419,591.60	1,097.00	OTHER LAB	185,779.00	258.00
MED/SURG SUPPLY	518,463.00	7,537.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	880.00	0.00
RADIOLOGY-DIAGNOSTIC	418,268.00	4,876.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,706,948.00	110,524.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	91,014.00	24,568.00	FEE SCHEDULE LAB	1,723,037.19	63,515.40
EKG/ECG	91,350.00	1,050.00	MRI SERVICES	1,285,828.00	74,343.00
IV THERAPY	288,596.00	3,160.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,686,156.00	136,178.00	DURABLE MED. EQUIP.	0.00	234.00
LABOR/DELIVERY ROOM	32,945.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61,485.00	2,426.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	374,323.00	6,672.00	AMBULANCE	0.00	0.00
GI SERVICES	8,787.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,366,623.00	29,221.00	SPECIAL SERVICES	0.00	374.00
RECOVERY ROOM	290,603.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	20,187.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,649,016.50	257,195.00
RADIOLOGY THERAPEUTIC	1,841,470.00	73,517.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,092.00	2,102.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,520.00	332.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	93,223.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,077.00	2,109.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,257.00	3,352.00	IMPL DEV CHARGE PATIENTS	171,695.00	17,303.00
LITHOTRIPSY	88,960.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	632,655.00	83,421.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	122,547.00	1,823.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	139,025.00	26,161.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	161,444.00	76,181.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,972.00	0.00			
ORGAN ACQUISITION	0.00	35,574.00			
TREATMENT/OBSERV. RM	125,093.10	7,910.00			
			TOTAL ANCILLARY	16,561,500.39	1,166,423.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,561,500.39	1,166,423.90

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

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

Run Date: 08/28/2018
Run Time: 23:29:20
Page: 7

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	462,872.40	ADJUSTMENTS	0.00
COVERED CHARGES	337,253.00	CONTRACTUAL ALLOW	189,497.70
NON-COVERD CHARGES	125,619.40	TOTAL MEDICAID LIAB	147,755.30
		LESS: COB	147,692.30
		LESS: COPAYMENT	63.00
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,414.00	0.00	OTHER LAB	15,936.00	0.00
MED/SURG SUPPLY	9,116.00	372.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	644.40	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,180.00	744.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,083.00	23,242.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	64,833.00	4,549.00
EKG/ECG	3,500.00	0.00	MRI SERVICES	0.00	18,475.00
IV THERAPY	3,989.00	1,188.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,017.00	35,929.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,952.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,082.00	163.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,558.00	1,326.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,895.00	11,407.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,127.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,035.00	7,748.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	350.00	40.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,257.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,583.00	15,803.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,732.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	771.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,832.00	0.00			
			TOTAL ANCILLARY	337,253.00	125,619.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	337,253.00	125,619.40

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

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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	456,203.00	ADJUSTMENTS	1,038.86
COVERED CHARGES	414,977.00	CONTRACTUAL ALLOW	405,467.20
NON-COVERD CHARGES	41,226.00	TOTAL MEDICAID LIAB	9,509.80
		LESS: COB	27.00
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	9,266.80
		TOTAL NUMBER OF CLAIMS	170

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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,161.50	0.00	OTHER LAB	1,329.00	0.00
MED/SURG SUPPLY	7,839.00	23.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,671.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,965.00	20,284.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,081.00	1,554.00
EKG/ECG	3,850.00	0.00	MRI SERVICES	15,425.00	9,396.00
IV THERAPY	386.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,989.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,410.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,062.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	190,461.00	3,640.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,613.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,898.50	2,311.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	40.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	838.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,820.00	3,140.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,016.00	0.00			
			TOTAL ANCILLARY	414,977.00	41,226.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	414,977.00	41,226.00

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,619.50	ADJUSTMENTS	0.00
COVERED CHARGES	27,729.50	CONTRACTUAL ALLOW	16,394.21
NON-COVERD CHARGES	1,890.00	TOTAL MEDICAID LIAB	11,335.29
		LESS: COB	11,323.29
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	163.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	186.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,557.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,994.00	218.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,178.00	218.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	651.00	557.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	897.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,729.50	1,890.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,729.50	1,890.00

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,824,430.40	ADJUSTMENTS	41,998.19
COVERED CHARGES	1,639,124.90	CONTRACTUAL ALLOW	1,477,039.31
NON-COVERD CHARGES	185,305.50	TOTAL MEDICAID LIAB	162,085.59
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	161,992.59

TOTAL NUMBER OF CLAIMS 27

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,940.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	331,128.90	247.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,036.00	15,800.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,220.00	8,719.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,212.00	3,554.00
EKG/ECG	5,950.00	0.00	MRI SERVICES	0.00	9,262.00
IV THERAPY	7,162.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	243,071.00	109,874.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,888.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,401.00	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	0.00	0.00	INJECTABLE DRUGS	273,306.50	19,590.50
RADIOLOGY THERAPEUTIC	170,224.00	3,638.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	389,577.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,320.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,139.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	62,581.00	14,621.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,524.00	0.00			
			TOTAL ANCILLARY	1,639,124.90	185,305.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,639,124.90	185,305.50

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH
1200 NORTHSIDE FORSYTH DR
CUMMING,GA 30041-7659

PROVIDER NUMBER
000000767A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	09/30/17
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: 08/28/2018
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,491,066.19	ADJUSTMENTS	617,221.79
COVERED CHARGES	25,066,294.59	CONTRACTUAL ALLOW	16,824,322.08
NON-COVERD CHARGES	424,771.60	TOTAL MEDICAID LIAB	8,241,972.51
		LESS: COB	64,021.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,177,951.14

TOTAL NUMBER OF ADMISSIONS 843

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,095		0	3,216,207.00		233,946.00
ROUTINE NURSERY	213		0	202,171.00		801.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,308		0	3,418,378.00		234,747.00
SPECIAL CARE SERVICES						
CCU	373		0	784,152.00		0.00
ICU	1,587		0	2,702,028.00		0.00
NICU	16		0	27,440.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,976		0	3,513,620.00		0.00
TOTAL ACCOMODATIONS	5,284		0	6,931,998.00		234,747.00

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,291,034.79	0.00	OTHER LAB	90,130.00	0.00
MED/SURG SUPPLY	1,667,570.98	11.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,015,119.52	0.00	EDUCATION & TRAINING	1,155.00	0.00
RADIOLOGY-DIAGNOSTIC	384,183.00	0.00	OTHER THERAPEUTIC SVC	0.00	942.00
CT SCAN	400,587.00	130,276.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	174,513.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	95,264.00	0.00	MRI SERVICES	213,757.00	0.00
IV THERAPY	431,620.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,271,625.00	7,094.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	132,064.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,490,529.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	461,299.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	352,047.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,245.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,165.00	0.00	INJECTABLE DRUGS	7,412.60	0.00
RADIOLOGY THERAPEUTIC	135,455.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	144,581.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	45,050.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	412,471.00	10,854.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	132.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,619.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	11,745.60
OTHER IMAGING SERVICE	71,313.00	4,471.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	445,462.00	20,214.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,980.00	4,285.00			
AUDIOLOGY	24,638.00	0.00			
CARDIOLOGY	899,145.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,092.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	177,169.00	0.00			
			TOTAL ANCILLARY	18,134,296.59	190,024.60
			TOTAL ACCOMODATIONS	6,931,998.00	234,747.00
			TOTAL CHARGES	25,066,294.59	424,771.60

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: 08/28/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
950	2216235008629	08/14/16 - 08/17/16	08/29/16	0.00	945.60	0.00	0.00	0.00
615	2316342000038	08/14/16 - 08/16/16	01/09/17	0.00	2,700.00	0.00	1,449.41	0.00
615	2217032013314	12/05/16 - 12/07/16	02/06/17	0.00	2,700.00	0.00	0.00	0.00
615	2217121001547	04/06/17 - 04/21/17	05/08/17	0.00	2,700.00	0.00	0.00	0.00
615	2217242005089	02/15/17 - 02/18/17	09/04/17	0.00	2,700.00	0.00	0.00	0.00
TOTAL				0.00	11,745.60	0.00	1,449.41	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: 08/28/2018
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	151,615.00	ADJUSTMENTS	0.00
COVERED CHARGES	145,489.00	CONTRACTUAL ALLOW	50,806.02
NON-COVERD CHARGES	6,126.00	TOTAL MEDICAID LIAB	94,682.98
		LESS: COB	94,682.98
		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	27		0	28,053.00		4,346.00
ROUTINE NURSERY	7		0	6,629.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	34		0	34,682.00		4,346.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	7,910.00		0.00
NICU	1		0	1,715.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6		0	9,625.00		0.00
TOTAL ACCOMODATIONS	40		0	44,307.00		4,346.00

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

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

Run Date: 08/28/2018
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,151.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,468.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,285.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,036.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,473.00	1,780.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	145.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	664.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,276.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,757.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,621.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,372.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,085.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,133.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,730.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	679.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	101,182.00	1,780.00
			TOTAL ACCOMODATIONS	44,307.00	4,346.00
			TOTAL CHARGES	145,489.00	6,126.00

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: 08/28/2018
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Page: 6

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,543,841.69	ADJUSTMENTS	480,831.88
COVERED CHARGES	9,365,849.18	CONTRACTUAL ALLOW	6,860,906.66
NON-COVERD CHARGES	1,177,992.51	TOTAL MEDICAID LIAB	2,504,942.52
		LESS: COB	1,999.89
		LESS: COPAYMENT	8,097.71
		REIMBURSEMENT	2,494,844.92
		ALL OTHER	1,920,348.46
		FEE SCHEDULE-LAB	231,232.76
		INJECTABLE DRUGS	343,263.70

TOTAL NUMBER OF CLAIMS 6,163

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	460,717.49	11,379.38	OTHER LAB	204,255.00	14,199.00
MED/SURG SUPPLY	414,630.24	2,763.94	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	171.00	116.00
RADIOLOGY-DIAGNOSTIC	421,051.00	7,928.00	OTHER THERAPEUTIC SVC	0.00	7,990.00
CT SCAN	792,796.00	94,120.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,003.00	19,949.06	FEE SCHEDULE LAB	1,188,359.76	75,152.50
EKG/ECG	82,228.00	2,320.00	MRI SERVICES	311,825.00	30,606.00
IV THERAPY	429,550.00	18,077.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	736,967.16	60,220.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,139.00	4,182.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	197,426.00	21,865.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,023.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	22,610.00	8,641.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,271,839.00	27,882.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	102,870.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	924,716.53	253,202.77
RADIOLOGY THERAPEUTIC	505,349.00	307,194.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,207.00	7,653.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,638.00	2,004.02	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	6,798.00	661.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	630.00
LITHOTRIPSY	49,420.00	0.00	NO CC/INVALID REV CODE	0.00	48.00
OTHER IMAGING SERVICE	346,543.00	62,902.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69,415.00	15,505.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,828.00	9,424.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	173,946.00	91,270.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,856.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	330,672.00	20,107.00			
			TOTAL ANCILLARY	9,365,849.18	1,177,992.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,365,849.18	1,177,992.51

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

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

Run Date: 08/28/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217347008198	09/30/16 - 09/30/16	12/18/17	0.00	48.00	0.00	0.00	0.00
TOTAL				0.00	48.00	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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	240,950.33	ADJUSTMENTS	0.00
COVERED CHARGES	158,700.38	CONTRACTUAL ALLOW	19,946.44
NON-COVERD CHARGES	82,249.95	TOTAL MEDICAID LIAB	138,753.94
		LESS: COB	138,547.68
		LESS: COPAYMENT	206.26
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 84

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

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,940.29	108.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,164.59	40.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,166.00	0.00	OTHER THERAPEUTIC SVC	0.00	615.00
CT SCAN	4,329.00	3,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,521.00	929.00
EKG/ECG	1,015.00	0.00	MRI SERVICES	0.00	1,690.00
IV THERAPY	13,696.00	209.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,147.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,520.00	980.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,805.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,070.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,772.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,975.50	1,567.15
RADIOLOGY THERAPEUTIC	42,950.00	60,754.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	253.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,637.00	7,321.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,739.00	854.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	3,282.00			
			TOTAL ANCILLARY	158,700.38	82,249.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	158,700.38	82,249.95

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

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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	579,355.52	ADJUSTMENTS	1,067.80
COVERED CHARGES	527,257.97	CONTRACTUAL ALLOW	498,560.75
NON-COVERD CHARGES	52,097.55	TOTAL MEDICAID LIAB	28,697.22
		LESS: COB	0.00
		LESS: COPAYMENT	1,128.61
		REIMBURSEMENT	27,568.61
		TOTAL NUMBER OF CLAIMS	513

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,973.56	1,189.00	OTHER LAB	4,590.00	4,005.00
MED/SURG SUPPLY	4,588.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,409.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	77,466.00	21,726.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	71,967.00	4,439.00
EKG/ECG	5,365.00	0.00	MRI SERVICES	3,720.00	0.00
IV THERAPY	31,948.00	664.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,362.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	233,098.00	1,018.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,107.41	4,610.55
RADIOLOGY THERAPEUTIC	655.00	11,088.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,282.00	3,358.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	949.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,778.00	0.00			
			TOTAL ANCILLARY	527,257.97	52,097.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	527,257.97	52,097.55

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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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,465.10	ADJUSTMENTS	0.00
COVERED CHARGES	9,307.80	CONTRACTUAL ALLOW	1,878.49
NON-COVERD CHARGES	3,157.30	TOTAL MEDICAID LIAB	7,429.31
		LESS: COB	7,420.31
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	347.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	538.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,180.00	2,434.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,246.00	387.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	664.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,002.00	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	289.60	336.30
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	9,307.80	3,157.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,307.80	3,157.30

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

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,390,677.27	ADJUSTMENTS	141,418.56
COVERED CHARGES	1,225,647.11	CONTRACTUAL ALLOW	908,894.63
NON-COVERD CHARGES	165,030.16	TOTAL MEDICAID LIAB	316,752.48
		LESS: COB	0.00
		LESS: COPAYMENT	411.21
		REIMBURSEMENT	316,341.27
		TOTAL NUMBER OF CLAIMS	58

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,746.80	2,241.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	190,079.36	91,520.56	RECREATIONAL THERAPY	123.00	123.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	116.00
RADIOLOGY-DIAGNOSTIC	3,765.00	2,694.00	OTHER THERAPEUTIC SVC	369.00	984.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,984.00	420.00
EKG/ECG	870.00	435.00	MRI SERVICES	0.00	0.00
IV THERAPY	53,421.00	2,277.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	303,273.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	102,753.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,895.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,036.00	233.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,540.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	453,313.95	14,355.20
RADIOLOGY THERAPEUTIC	3,399.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	36.20
OTHER IMAGING SERVICE	4,017.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,920.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	58,359.00	47,674.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,783.00	1,921.00			
			TOTAL ANCILLARY	1,225,647.11	165,030.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,225,647.11	165,030.16

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

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5917145001152	02/16/17 - 02/21/17	05/29/17	0.00	36.20	0.00	0.00	0.00
TOTAL				0.00	36.20	0.00	0.00	0.00

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,761.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,007.00	CONTRACTUAL ALLOW	3,768.48
NON-COVERD CHARGES	3,754.00	TOTAL MEDICAID LIAB	17,238.52
		LESS: COB	17,232.52
		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

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	852.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,308.00	2,742.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37.00	224.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,390.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	692.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	315.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	321.00	788.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,092.00	0.00			
			TOTAL ANCILLARY	21,007.00	3,754.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,007.00	3,754.00

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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,250,746.02	ADJUSTMENTS	198,659.59
COVERED CHARGES	12,751,645.73	CONTRACTUAL ALLOW	10,108,237.46
NON-COVERD CHARGES	499,100.29	TOTAL MEDICAID LIAB	2,643,408.27
		LESS: COB	5,729.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,637,678.87

TOTAL NUMBER OF ADMISSIONS 345

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	559	0	456,204.92	57,491.39
ROUTINE NURSERY	99	0	58,797.06	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	658	0	515,001.98	57,491.39
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	613	0	1,130,722.42	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	613	0	1,130,722.42	0.00
TOTAL ACCOMODATIONS	1,271	0	1,645,724.40	57,491.39

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,648.49	0.00	OTHER LAB	44,141.94	0.00
MED/SURG SUPPLY	186,739.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,194,006.73	0.00	EDUCATION & TRAINING	75.26	0.00
RADIOLOGY-DIAGNOSTIC	244,818.39	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	289,646.22	409,527.86	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	112,309.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	172,121.92	0.00	MRI SERVICES	67,415.42	0.00
IV THERAPY	92,740.63	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,767,864.92	168.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	158,054.34	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	964,555.29	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	343,745.42	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,213.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	399,531.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	76,749.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	54,477.93	0.00	INJECTABLE DRUGS	1,712,629.91	0.00
RADIOLOGY THERAPEUTIC	65,575.29	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,687.35	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	757.37	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,115,562.71	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,178.04
OTHER IMAGING SERVICE	101,078.53	6,889.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,747.42	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	157,958.84	17,845.77			
AUDIOLOGY	8,093.78	0.00			
CARDIOLOGY	342,298.72	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,326.93	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,349.36	0.00			
			TOTAL ANCILLARY	11,105,921.33	441,608.90
			TOTAL ACCOMODATIONS	1,645,724.40	57,491.39
			TOTAL CHARGES	12,751,645.73	499,100.29

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: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217199011968	05/09/17 - 05/10/17	07/24/17	0.00	4,350.79	0.00	0.00	0.00
615	2018113027503	05/04/17 - 05/13/17	04/30/18	0.00	2,827.25	0.00	0.00	0.00
TOTAL				0.00	7,178.04	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
 SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 08/28/2018
 Run Time: 23:45:36
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,754.87	ADJUSTMENTS	0.00
COVERED CHARGES	16,754.87	CONTRACTUAL ALLOW	8,765.13
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	7,989.74
		LESS: COB	7,989.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	0		0	0.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	0		0	0.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,383.17		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	1,383.17		0.00
TOTAL ACCOMODATIONS	1		0	1,383.17		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,507.16	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	575.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	476.18	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,108.72	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,078.32	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	1,349.42	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	1,440.77	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,531.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,371.70	0.00
			TOTAL ACCOMODATIONS	1,383.17	0.00
			TOTAL CHARGES	16,754.87	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: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,950,542.20	ADJUSTMENTS	193,353.64
COVERED CHARGES	15,364,696.91	CONTRACTUAL ALLOW	13,706,252.18
NON-COVERD CHARGES	2,585,845.29	TOTAL MEDICAID LIAB	1,658,444.73
		LESS: COB	1,645.56
		LESS: COPAYMENT	5,474.58
		REIMBURSEMENT	1,651,324.59
		ALL OTHER	1,384,850.11
		FEE SCHEDULE-LAB	194,298.94
		INJECTABLE DRUGS	72,175.54

TOTAL NUMBER OF CLAIMS 5,053

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,053.09	27,483.74	OTHER LAB	83,345.34	1,202.97
MED/SURG SUPPLY	191,695.73	890.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	759,091.34	16,365.97	OTHER THERAPEUTIC SVC	0.00	894.22
CT SCAN	2,514,237.75	530,449.31	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	227,217.24	20,597.26	FEE SCHEDULE LAB	3,171,246.90	213,272.18
EKG/ECG	272,158.60	13,199.70	MRI SERVICES	354,457.75	47,157.87
IV THERAPY	773,980.85	128,097.57	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,400,809.28	463,325.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,722.28	5,591.56	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,906.93	6,492.91	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	363,075.55	14,956.31	AMBULANCE	0.00	0.00
GI SERVICES	47,235.50	24,786.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,755,524.61	8,812.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	132,957.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	511,058.15	150,230.02
RADIOLOGY THERAPEUTIC	447,377.50	300,825.22	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	743.47	1,837.71	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	937.19	2,851.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,365.03	273,513.12
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,767.59
OTHER IMAGING SERVICE	325,717.76	72,663.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,138.86	14,942.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	357,303.31	130,265.90			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	180,554.32	105,062.76			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	140,742.99	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	246,042.59	4,310.12			
			TOTAL ANCILLARY	15,364,696.91	2,585,845.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,364,696.91	2,585,845.29

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

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

Run Date: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017285070236	09/29/17 - 09/29/17	10/16/17	0.00	1,922.53	0.00	0.00	0.00
615	2017348075283	09/27/17 - 09/27/17	12/18/17	0.00	1,922.53	0.00	0.00	0.00
615	2017348075283	09/27/17 - 09/27/17	12/18/17	0.00	1,922.53	0.00	0.00	0.00
TOTAL				0.00	5,767.59	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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	187,293.30	ADJUSTMENTS	0.00
COVERED CHARGES	119,439.73	CONTRACTUAL ALLOW	44,809.17
NON-COVERD CHARGES	67,853.57	TOTAL MEDICAID LIAB	74,630.56
		LESS: COB	74,587.01
		LESS: COPAYMENT	43.55
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27.42	440.01	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,921.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,778.21	53,084.88	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,823.23	2,585.25
EKG/ECG	952.36	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,160.12	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,148.74	5,692.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	394.01	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	199.48	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,039.18	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,136.10	1,109.39
RADIOLOGY THERAPEUTIC	1,992.72	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,532.83	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,482.46	3,228.21			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	851.22	1,713.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	119,439.73	67,853.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	119,439.73	67,853.57

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

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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	668,580.41	ADJUSTMENTS	0.00
COVERED CHARGES	614,737.78	CONTRACTUAL ALLOW	597,004.80
NON-COVERD CHARGES	53,842.63	TOTAL MEDICAID LIAB	17,732.98
		LESS: COB	0.00
		LESS: COPAYMENT	591.11
		REIMBURSEMENT	17,141.87
		TOTAL NUMBER OF CLAIMS	317

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

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

Run Date: 08/28/2018
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SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL
 1035 RED BUD RD NE
 CALHOUN,GA 30701-2082

PROVIDER NUMBER
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	447.97	561.70	OTHER LAB	1,282.90	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,769.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	129,148.36	37,600.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	109,768.62	4,898.39
EKG/ECG	7,485.54	0.00	MRI SERVICES	4,568.72	0.00
IV THERAPY	42,507.62	3,250.55	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	269,211.88	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	5,046.68	288.10
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	4,828.66	5,529.88			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,671.10	1,713.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	614,737.78	53,842.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	614,737.78	53,842.63

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

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	982.92	27.54
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	618.74	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,867.29	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	423.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,892.00	27.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,892.00	27.54

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

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

Run Date: 08/28/2018
Run Time: 23:46:30
Page: 15

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,481,497.16	ADJUSTMENTS	33,244.38
COVERED CHARGES	1,392,297.96	CONTRACTUAL ALLOW	1,153,853.07
NON-COVERD CHARGES	89,199.20	TOTAL MEDICAID LIAB	238,444.89
		LESS: COB	0.00
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	238,129.89

TOTAL NUMBER OF CLAIMS 43

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,775.34	347.81	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,993.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,272.80	802.33	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,550.27	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,463.07	0.00
EKG/ECG	476.18	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	45,243.85	2,714.73	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,807.69	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,040.68	598.44	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,295.00	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	1,943.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,108,748.79	59,292.14
RADIOLOGY THERAPEUTIC	119,739.59	23,002.59	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,100.15	2,441.16
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,847.76	0.00			
			TOTAL ANCILLARY	1,392,297.96	89,199.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,392,297.96	89,199.20

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: 08/28/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/28/2018
 Run Time: 23:56:03
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,626,529.37	ADJUSTMENTS	1,160,184.58
COVERED CHARGES	47,833,332.92	CONTRACTUAL ALLOW	40,119,885.75
NON-COVERD CHARGES	793,196.45	TOTAL MEDICAID LIAB	7,713,447.17
		LESS: COB	110,049.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,603,397.97

TOTAL NUMBER OF ADMISSIONS 883

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,305	4	4,300,406.00	175,954.00
ROUTINE NURSERY	210	0	217,923.00	9,075.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,515	4	4,518,329.00	185,029.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	898	0	2,062,023.00	4,772.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	898	0	2,062,023.00	4,772.00
TOTAL ACCOMODATIONS	4,413	4	6,580,352.00	189,801.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,793,916.20	27,595.27	OTHER LAB	170,254.86	0.00
MED/SURG SUPPLY	4,454,036.02	26,224.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,996,103.10	6,604.57	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	837,687.84	1,149.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,262,593.96	6,481.78	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	248,456.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	283,374.00	0.00	MRI SERVICES	513,939.86	0.00
IV THERAPY	2,865.07	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,876,702.42	2,369.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	283,249.09	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,466,296.41	13,693.43	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	840,735.89	0.00	AMBULANCE	0.00	0.00
GI SERVICES	204,035.28	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,886,541.27	2,069.81	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	236,744.18	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	182,740.47	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	63,017.24	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	63,818.38	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	126,098.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	319,361.28	13,306.72	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,530.19	136.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	443,716.96	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	213,345.52	15,262.14			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,737.05	488,501.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	348,716.61	0.00			
AUDIOLOGY	2,518.64	0.00			
CARDIOLOGY	1,666,279.96	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,236.62	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	378,331.55	0.00			
			TOTAL ANCILLARY	41,252,980.92	603,395.45
			TOTAL ACCOMODATIONS	6,580,352.00	189,801.00
			TOTAL CHARGES	47,833,332.92	793,196.45

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

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

Run Date: 08/28/2018
 Run Time: 23:56:10
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,802.26	ADJUSTMENTS	0.00
COVERED CHARGES	70,602.26	CONTRACTUAL ALLOW	44,843.92
NON-COVERD CHARGES	200.00	TOTAL MEDICAID LIAB	25,758.34
		LESS: COB	25,758.34
		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	5,208.00		200.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	5,208.00		200.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	4		0	5,208.00		200.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,190.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,862.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,091.52	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	599.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,611.24	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	10,370.85	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,996.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,827.13	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,968.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	707.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	136.17	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,623.94	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	65,394.26	0.00
			TOTAL ACCOMODATIONS	5,208.00	200.00
			TOTAL CHARGES	70,602.26	200.00

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: 08/28/2018
Run Time: 23:56:11
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,039,191.42	ADJUSTMENTS	584,252.77
COVERED CHARGES	23,378,915.45	CONTRACTUAL ALLOW	20,890,116.54
NON-COVERD CHARGES	1,660,275.97	TOTAL MEDICAID LIAB	2,488,798.91
		LESS: COB	1,768.10
		LESS: COPAYMENT	5,067.51
		REIMBURSEMENT	2,481,963.30
		ALL OTHER	2,192,505.81
		FEE SCHEDULE-LAB	221,650.04
		INJECTABLE DRUGS	67,807.45

TOTAL NUMBER OF CLAIMS 6,099

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	930,014.98	1,748.86	OTHER LAB	208,742.02	860.61
MED/SURG SUPPLY	1,479,520.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,312,986.17	17,742.76	OTHER THERAPEUTIC SVC	0.00	185.19
CT SCAN	2,606,418.09	341,844.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	40,732.27	19,542.77	FEE SCHEDULE LAB	3,599,959.59	37,605.18
EKG/ECG	443,898.00	819.00	MRI SERVICES	315,265.04	83,936.35
IV THERAPY	636,853.43	3,197.35	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,108,808.22	129,239.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	496,022.04	14,254.55	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	558,583.57	0.00	AMBULANCE	0.00	0.00
GI SERVICES	65,313.63	22,522.87	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,683,730.18	5,291.54	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	118,159.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,179.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,243,438.76	487,602.89
RADIOLOGY THERAPEUTIC	6,149.52	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,303.51	14,582.67	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,907.50	15,464.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,504.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41,625.93	12,832.68	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	80,785.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	452,820.41	146,869.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,750.68	116,922.90			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	333,817.29	40,301.45			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	438,549.61	128,535.38			
AMBULATORY SURGERY	29,108.02	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	419,191.54	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	710,460.64	6,688.74			
			TOTAL ANCILLARY	23,378,915.45	1,660,275.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,378,915.45	1,660,275.97

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: 08/28/2018
Run Time: 23:56:38
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,478.15	ADJUSTMENTS	0.00
COVERED CHARGES	43,281.01	CONTRACTUAL ALLOW	39,271.33
NON-COVERD CHARGES	8,197.14	TOTAL MEDICAID LIAB	4,009.68
		LESS: COB	4,000.68
		LESS: COPAYMENT	9.00
		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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,865.09	0.00	OTHER LAB	860.61	0.00
MED/SURG SUPPLY	5,466.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	383.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,698.37	43.58
EKG/ECG	409.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	294.13	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,926.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157.96	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,246.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,464.21	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	855.16	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,416.22	890.90
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	315.92	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	5,087.38	1,122.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	5,757.35			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,331.26	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	4,885.83	0.00			
			TOTAL ANCILLARY	43,281.01	8,197.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,281.01	8,197.14

Report : CLM-0808-0
Process : CLMJ0800
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: 08/28/2018
Run Time: 23:56:39
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,120,588.65	ADJUSTMENTS	695.73
COVERED CHARGES	1,970,957.84	CONTRACTUAL ALLOW	1,922,793.50
NON-COVERD CHARGES	149,630.81	TOTAL MEDICAID LIAB	48,164.34
		LESS: COB	0.00
		LESS: COPAYMENT	1,878.79
		REIMBURSEMENT	46,285.55
		TOTAL NUMBER OF CLAIMS	861

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,587.17	5.45	OTHER LAB	8,467.92	0.00
MED/SURG SUPPLY	21,705.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	135,964.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	230,307.52	104,205.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,435.91	FEE SCHEDULE LAB	307,288.73	7,483.68
EKG/ECG	30,712.50	0.00	MRI SERVICES	4,232.22	0.00
IV THERAPY	75,591.58	996.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,775.68	501.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,635.44	310.47	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	950,348.91	1,394.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81,243.59	7,800.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,191.71	21,798.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,699.43			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,874.95	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,029.46	0.00			
			TOTAL ANCILLARY	1,970,957.84	149,630.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,970,957.84	149,630.81

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 SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,803.90	ADJUSTMENTS	0.00
COVERED CHARGES	1,803.90	CONTRACTUAL ALLOW	1,635.40
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	168.50
		LESS: COB	168.50
		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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,394.40	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	1,803.90	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,803.90	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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	914,429.91	ADJUSTMENTS	32,625.60
COVERED CHARGES	836,053.69	CONTRACTUAL ALLOW	710,919.89
NON-COVERD CHARGES	78,376.22	TOTAL MEDICAID LIAB	125,133.80
		LESS: COB	0.00
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	125,025.80
		TOTAL NUMBER OF CLAIMS	23

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

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
 601 S 8TH ST
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,964.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	164,994.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,936.54	8,856.62	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,115.61	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,438.13	0.00
EKG/ECG	1,638.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,398.84	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	198,012.84	19,898.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,975.22	1,198.34	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,063.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,069.81	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,969.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	191,069.60	31,592.26
RADIOLOGY THERAPEUTIC	16,743.69	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	90,479.02	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,419.11	16,830.84			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,882.60	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,882.73	0.00			
			TOTAL ANCILLARY	836,053.69	78,376.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	836,053.69	78,376.22

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: 08/28/2018
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Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC
601 S 8TH ST
GRIFFIN,GA 30224-4213

PROVIDER NUMBER
000000866A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/28/2018
 Run Time: 23:52:42
 Page: 1

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,749,035.26	ADJUSTMENTS	5,943,340.58
COVERED CHARGES	132,817,837.76	CONTRACTUAL ALLOW	103,038,711.10
NON-COVERD CHARGES	2,931,197.50	TOTAL MEDICAID LIAB	29,779,126.66
		LESS: COB	148,460.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,630,665.95

TOTAL NUMBER OF ADMISSIONS 3,126

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,988		0	12,294,157.00		2,149,772.00
ROUTINE NURSERY	2,564		0	2,471,001.00		107,460.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14,552		0	14,765,158.00		2,257,232.00
SPECIAL CARE SERVICES						
CCU	369		0	750,572.00		0.00
ICU	2,201		0	4,815,290.00		0.00
NICU	98		0	219,674.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		13	0.00		14,729.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,668		13	5,785,536.00		14,729.00
TOTAL ACCOMODATIONS	17,220		13	20,550,694.00		2,271,961.00

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

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

Run Date: 08/28/2018
 Run Time: 23:52:42
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN
 743 SPRING ST NE
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
 000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,223,687.23	3,133.00	OTHER LAB	578,711.00	0.00
MED/SURG SUPPLY	9,433,034.16	34,545.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,636,249.93	10,898.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,262,497.50	0.00	OTHER THERAPEUTIC SVC	85,405.00	0.00
CT SCAN	7,007,527.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	580,769.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	699,431.00	0.00	MRI SERVICES	1,410,441.00	0.00
IV THERAPY	1,647,414.00	22,437.00	PROFESSIONAL FEES	0.00	50.00
OPERATING ROOM	10,538,315.50	14,511.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,024,579.00	3,838.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,412,704.00	40,434.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,611,847.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,982,456.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,553,339.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,620.00
LABORATORY PATHOLOGIC	560,789.30	0.00	INJECTABLE DRUGS	9,725,372.00	0.00
RADIOLOGY THERAPEUTIC	313,831.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	234,467.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	269,455.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	812,811.00	192,314.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,118.00	1,949.00	TRAUMA RESPONSE	0.00	104,544.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,754,863.14	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	746,641.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	731,963.00	86,208.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	574,608.00	134,996.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,079,381.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	350,375.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	401,062.00	5,759.00			
			TOTAL ANCILLARY	112,267,143.76	659,236.50
			TOTAL ACCOMODATIONS	20,550,694.00	2,271,961.00
			TOTAL CHARGES	132,817,837.76	2,931,197.50

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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,311,696.05	ADJUSTMENTS	0.00
COVERED CHARGES	1,857,367.05	CONTRACTUAL ALLOW	723,144.63
NON-COVERD CHARGES	454,329.00	TOTAL MEDICAID LIAB	1,134,222.42
		LESS: COB	1,134,222.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 93

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	239		0	229,722.00		67,508.00
ROUTINE NURSERY	59		0	62,344.00		2,630.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	298		0	292,066.00		70,138.00
SPECIAL CARE SERVICES						
CCU	1		0	0.00		2,270.00
ICU	27		0	52,210.00		9,080.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	28		0	52,210.00		11,350.00
TOTAL ACCOMODATIONS	326		0	344,276.00		81,488.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222,326.05	34,409.00	OTHER LAB	1,714.00	1,714.00
MED/SURG SUPPLY	97,863.00	49,447.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	164,827.00	36,640.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,394.00	3,962.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,588.00	16,853.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,872.00	578.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,784.00	2,890.00	MRI SERVICES	3,574.00	13,165.00
IV THERAPY	9,624.00	11,458.00	PROFESSIONAL FEES	0.00	150.00
OPERATING ROOM	186,255.00	34,465.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	253,280.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66,542.00	20,968.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	144,152.00	10,622.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,019.00	9,594.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	110,405.00	18,202.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,786.00	1,437.00	INJECTABLE DRUGS	89,942.00	10,421.00
RADIOLOGY THERAPEUTIC	712.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,818.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,422.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,946.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	535.00	246.00	TRAUMA RESPONSE	0.00	2,723.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,975.00	26,033.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,699.00	1,493.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,304.00	1,304.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,803.00	49,894.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,610.00	1,610.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,320.00	12,563.00			
			TOTAL ANCILLARY	1,513,091.05	372,841.00
			TOTAL ACCOMODATIONS	344,276.00	81,488.00
			TOTAL CHARGES	1,857,367.05	454,329.00

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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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,546,717.63	ADJUSTMENTS	1,064,273.40
COVERED CHARGES	43,199,529.63	CONTRACTUAL ALLOW	36,841,760.73
NON-COVERD CHARGES	7,347,188.00	TOTAL MEDICAID LIAB	6,357,768.90
		LESS: COB	6,890.69
		LESS: COPAYMENT	15,247.79
		REIMBURSEMENT	6,335,630.42
		ALL OTHER	5,363,275.91
		FEE SCHEDULE-LAB	645,511.03
		INJECTABLE DRUGS	326,843.48

TOTAL NUMBER OF CLAIMS 12,786

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,459,552.00	4,679.00	OTHER LAB	532,752.00	582.00
MED/SURG SUPPLY	977,431.00	313,094.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,334,614.00	31,129.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,483,665.00	647,862.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	185,231.00	37,654.00	FEE SCHEDULE LAB	7,754,049.83	480,467.00
EKG/ECG	595,374.00	19,363.00	MRI SERVICES	1,289,269.00	136,831.00
IV THERAPY	1,930,989.00	385,236.00	PROFESSIONAL FEES	0.00	308.00
OPERATING ROOM	3,002,280.00	439,900.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	70,676.00	10,335.00	REHAB THERAPY	0.00	5,869.00
RESPIRATORY SERVICES	185,438.00	118,839.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	915,480.00	10,764.00	AMBULANCE	0.00	0.00
GI SERVICES	6,568.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,259,968.00	5,246.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,023,361.00	5,099.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,978,654.80	1,262,536.00
RADIOLOGY THERAPEUTIC	2,013,720.00	858,793.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	26,239.00	21,341.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,872.00	5,999.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	51,605.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	622.00	8,849.00	TRAUMA RESPONSE	0.00	53,915.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	88,933.00	1,058,442.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,593,063.00	72,086.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	78,541.00	79,902.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,051,677.00	444,465.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,460,055.00	677,917.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	721,916.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,170,539.00	98,081.00			
			TOTAL ANCILLARY	43,199,529.63	7,347,188.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,199,529.63	7,347,188.00

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

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

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

NORTHEAST GEORGIA MEDICAL CENTER IN
743 SPRING ST NE
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,257,125.60	ADJUSTMENTS	0.00
COVERED CHARGES	985,471.60	CONTRACTUAL ALLOW	542,189.58
NON-COVERD CHARGES	271,654.00	TOTAL MEDICAID LIAB	443,282.02
		LESS: COB	443,057.27
		LESS: COPAYMENT	224.75
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,564.00	0.00	OTHER LAB	5,934.00	0.00
MED/SURG SUPPLY	37,422.00	28,424.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,355.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	90,488.00	36,992.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	616.00	0.00	FEE SCHEDULE LAB	140,731.00	8,588.00
EKG/ECG	11,271.00	0.00	MRI SERVICES	38,422.00	20,819.00
IV THERAPY	43,738.00	2,301.00	PROFESSIONAL FEES	0.00	250.00
OPERATING ROOM	132,118.00	19,759.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,733.00	542.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,120.00	744.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,666.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,642.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	123,040.00	673.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	48,209.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,122.60	90,654.00
RADIOLOGY THERAPEUTIC	23,126.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	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	107.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	729.00	13,159.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,612.00	1,329.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,488.00	1,737.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,825.00	2,671.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,515.00	38,606.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,397.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,588.00	287.00			
			TOTAL ANCILLARY	985,471.60	271,654.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	985,471.60	271,654.00

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,283,562.00	ADJUSTMENTS	534.33
COVERED CHARGES	1,222,074.00	CONTRACTUAL ALLOW	1,180,342.76
NON-COVERD CHARGES	61,488.00	TOTAL MEDICAID LIAB	41,731.24
		LESS: COB	0.00
		LESS: COPAYMENT	1,246.18
		REIMBURSEMENT	40,485.06
		TOTAL NUMBER OF CLAIMS	746

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,343.00	0.00	OTHER LAB	2,506.00	0.00
MED/SURG SUPPLY	18,117.00	1,868.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109,121.00	924.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,586.00	2,088.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	195,163.00	13,407.00
EKG/ECG	20,519.00	0.00	MRI SERVICES	2,474.00	0.00
IV THERAPY	55,730.00	892.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,341.00	10,934.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,480.00	293.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,939.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	657,535.00	698.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,060.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,879.00	2,147.00
RADIOLOGY THERAPEUTIC	764.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	107.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	24,207.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,299.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,304.00	1,737.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,492.00	2,186.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,422.00	0.00			
			TOTAL ANCILLARY	1,222,074.00	61,488.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,222,074.00	61,488.00

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

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

Run Date: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,049.00	ADJUSTMENTS	0.00
COVERED CHARGES	50,822.00	CONTRACTUAL ALLOW	32,718.17
NON-COVERD CHARGES	12,227.00	TOTAL MEDICAID LIAB	18,103.83
		LESS: COB	18,085.64
		LESS: COPAYMENT	18.19
		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: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,833.00	0.00	OTHER LAB	1,253.00	0.00
MED/SURG SUPPLY	182.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,629.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,594.00	10,087.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,486.00	210.00
EKG/ECG	867.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,893.00	1,896.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	960.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,835.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	99.00	34.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,191.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	50,822.00	12,227.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,822.00	12,227.00

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,839,693.96	ADJUSTMENTS	144,076.98
COVERED CHARGES	5,419,350.96	CONTRACTUAL ALLOW	4,742,832.90
NON-COVERD CHARGES	420,343.00	TOTAL MEDICAID LIAB	676,518.06
		LESS: COB	0.00
		LESS: COPAYMENT	654.65
		REIMBURSEMENT	675,863.41
		TOTAL NUMBER OF CLAIMS	122

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

NORTHEAST GEORGIA MEDICAL CENTER IN
 743 SPRING ST NE
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER
 000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164,564.00	1,034.00	OTHER LAB	2,374.00	0.00
MED/SURG SUPPLY	338,062.96	62,880.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,393.00	4,520.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,569.00	10,087.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	148.00	FEE SCHEDULE LAB	81,706.00	10,562.00
EKG/ECG	13,005.00	0.00	MRI SERVICES	3,574.00	0.00
IV THERAPY	114,182.00	25,782.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,091,810.00	24,785.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,690.00	16,960.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	340,792.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,246.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	304,081.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,252,462.00	26,319.00
RADIOLOGY THERAPEUTIC	378,668.00	54,088.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	312.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	107.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93,156.00	172,833.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,950.00	1,914.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,099.00	127.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,368.00	7,885.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,599.00	0.00			
			TOTAL ANCILLARY	5,419,350.96	420,343.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,419,350.96	420,343.00

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: 08/28/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/28/2018
 Run Time: 23:54:49
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER 000000888S
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,963,837.80	ADJUSTMENTS	273,036.13
COVERED CHARGES	11,848,651.80	CONTRACTUAL ALLOW	9,037,594.46
NON-COVERD CHARGES	115,186.00	TOTAL MEDICAID LIAB	2,811,057.34
		LESS: COB	20,019.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,791,037.53

TOTAL NUMBER OF ADMISSIONS 297

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	941		0	962,244.00		72,413.00
ROUTINE NURSERY	249		0	281,470.00		22,536.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,190		0	1,243,714.00		94,949.00
SPECIAL CARE SERVICES						
CCU	8		0	18,160.00		0.00
ICU	131		0	274,130.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	139		0	292,290.00		0.00
TOTAL ACCOMODATIONS	1,329		0	1,536,004.00		94,949.00

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

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

Run Date: 08/28/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,559,843.20	0.00	OTHER LAB	66,614.00	0.00
MED/SURG SUPPLY	824,686.00	2,334.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,505,872.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,795.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	737,553.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,946.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	85,255.00	0.00	MRI SERVICES	196,739.00	0.00
IV THERAPY	246,733.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,012,463.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	60,979.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	638,012.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364,990.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	341,626.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	294,590.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	69,840.00	0.00	INJECTABLE DRUGS	893,834.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,519.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,748.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	37,365.00	7,659.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,712.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	676,024.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	77,714.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	74,857.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,012.00	10,244.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	213,110.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,728.00	0.00			
			TOTAL ANCILLARY	10,312,647.80	20,237.00
			TOTAL ACCOMODATIONS	1,536,004.00	94,949.00
			TOTAL CHARGES	11,848,651.80	115,186.00

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

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

Run Date: 08/28/2018
 Run Time: 23:54:52
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	244,483.00	ADJUSTMENTS	0.00
COVERED CHARGES	236,001.00	CONTRACTUAL ALLOW	123,880.70
NON-COVERD CHARGES	8,482.00	TOTAL MEDICAID LIAB	112,120.30
		LESS: COB	112,120.30
		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	21		0	21,105.00		4,925.00
ROUTINE NURSERY	16		0	17,588.00		2,088.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	37		0	38,693.00		7,013.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	4,540.00		0.00
NICU	1		0	1,876.00		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	3		0	6,416.00		0.00
TOTAL ACCOMODATIONS	40		0	45,109.00		7,013.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,173.00	21.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,057.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	21,265.00	472.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	750.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,911.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,315.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	289.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	830.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,005.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,575.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,657.00	667.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,486.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,574.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,985.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	323.00	0.00	INJECTABLE DRUGS	3,483.00	309.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,214.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	190,892.00	1,469.00
			TOTAL ACCOMODATIONS	45,109.00	7,013.00
			TOTAL CHARGES	236,001.00	8,482.00

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: 08/28/2018
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NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,666,375.60	ADJUSTMENTS	97,515.42
COVERED CHARGES	6,980,056.60	CONTRACTUAL ALLOW	5,652,008.90
NON-COVERD CHARGES	686,319.00	TOTAL MEDICAID LIAB	1,328,047.70
		LESS: COB	6,759.29
		LESS: COPAYMENT	1,896.32
		REIMBURSEMENT	1,319,392.09
		ALL OTHER	1,215,756.17
		FEE SCHEDULE-LAB	82,726.50
		INJECTABLE DRUGS	20,909.42

TOTAL NUMBER OF CLAIMS 1,689

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

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

Run Date: 08/28/2018
 Run Time: 23:54:52
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NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195,505.00	195.00	OTHER LAB	108,157.00	1,714.00
MED/SURG SUPPLY	124,027.00	24,249.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	310,140.00	2,599.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,552,024.00	151,026.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,525.00	FEE SCHEDULE LAB	1,066,241.00	61,857.00
EKG/ECG	125,341.00	1,445.00	MRI SERVICES	378,814.00	24,628.00
IV THERAPY	388,131.00	75,838.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	522,940.00	103,244.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,496.00	622.00	REHAB THERAPY	0.00	255.00
RESPIRATORY SERVICES	40,785.00	7,329.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	154,161.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,228,359.00	3,379.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	135,118.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	125,536.60	67,638.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	360.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,605.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,572.00	30,881.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	184,304.00	21,920.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,213.00	14,548.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,441.00	42,270.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	164,102.00	46,024.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,709.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	70,940.00	1,168.00			
			TOTAL ANCILLARY	6,980,056.60	686,319.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,980,056.60	686,319.00

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

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

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

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	293,935.00	ADJUSTMENTS	0.00
COVERED CHARGES	228,243.00	CONTRACTUAL ALLOW	115,980.32
NON-COVERD CHARGES	65,692.00	TOTAL MEDICAID LIAB	112,262.68
		LESS: COB	112,232.68
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 56

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

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,719.00	0.00	OTHER LAB	2,374.00	0.00
MED/SURG SUPPLY	10,062.00	467.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,282.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,627.00	13,025.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,576.00	3,314.00
EKG/ECG	3,468.00	0.00	MRI SERVICES	2,623.00	0.00
IV THERAPY	9,336.00	1,850.00	PROFESSIONAL FEES	0.00	100.00
OPERATING ROOM	21,613.00	23,088.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	831.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	960.00	293.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,162.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,818.00	1,355.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,325.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,268.00	1,776.00
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	0.00	107.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156.00	7,770.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,904.00	2,163.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,556.00	7,783.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,550.00	2,601.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,439.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	594.00	0.00			
			TOTAL ANCILLARY	228,243.00	65,692.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	228,243.00	65,692.00

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 INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	830,175.00	ADJUSTMENTS	373.58
COVERED CHARGES	768,768.00	CONTRACTUAL ALLOW	753,832.02
NON-COVERD CHARGES	61,407.00	TOTAL MEDICAID LIAB	14,935.98
		LESS: COB	0.00
		LESS: COPAYMENT	530.01
		REIMBURSEMENT	14,405.97
		TOTAL NUMBER OF CLAIMS	267

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,085.00	0.00	OTHER LAB	4,220.00	0.00
MED/SURG SUPPLY	14,800.00	252.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,028.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	144,254.00	34,203.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	468.00	FEE SCHEDULE LAB	123,166.00	6,698.00
EKG/ECG	15,028.00	289.00	MRI SERVICES	26,999.00	0.00
IV THERAPY	37,188.00	9,601.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,683.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,600.00	613.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,779.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	267,146.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,301.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,332.00	2,941.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	214.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,245.00	3,942.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,492.00	2,186.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,422.00	0.00			
			TOTAL ANCILLARY	768,768.00	61,407.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	768,768.00	61,407.00

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 INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,014.00	ADJUSTMENTS	0.00
COVERED CHARGES	34,352.00	CONTRACTUAL ALLOW	19,285.34
NON-COVERD CHARGES	5,662.00	TOTAL MEDICAID LIAB	15,066.66
		LESS: COB	15,045.66
		LESS: COPAYMENT	21.00
		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

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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	644.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,759.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,446.00	2,088.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,477.00	0.00
EKG/ECG	578.00	0.00	MRI SERVICES	2,979.00	3,574.00
IV THERAPY	1,464.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,102.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,868.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,352.00	5,662.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,352.00	5,662.00

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

NORTHEAST GEORGIA MEDICAL CENTER INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	841,469.00	ADJUSTMENTS	15,588.72
COVERED CHARGES	735,349.00	CONTRACTUAL ALLOW	623,550.72
NON-COVERD CHARGES	106,120.00	TOTAL MEDICAID LIAB	111,798.28
		LESS: COB	0.00
		LESS: COPAYMENT	101.90
		REIMBURSEMENT	111,696.38
		TOTAL NUMBER OF CLAIMS	22

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

NORTHEAST GEORGIA MEDICAL CENTER INC.
 1400 RIVER PLACE
 BRASELTON,GA 30517-5600

PROVIDER NUMBER
 000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,514.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	140,342.00	19,135.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	718.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,233.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	148.00	FEE SCHEDULE LAB	16,128.00	2,448.00
EKG/ECG	3,757.00	289.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,957.00	2,016.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	283,626.00	26,114.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,196.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,503.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	91,768.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,247.00	2,375.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	508.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,800.00	49,613.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,912.00	3,474.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,970.00	0.00			
			TOTAL ANCILLARY	735,349.00	106,120.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	735,349.00	106,120.00

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 INC.
1400 RIVER PLACE
BRASELTON,GA 30517-5600

PROVIDER NUMBER
000000888S

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,383.00	ADJUSTMENTS	0.00
COVERED CHARGES	33,383.00	CONTRACTUAL ALLOW	18,599.55
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,783.45
		LESS: COB	14,783.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER INC.	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1400 RIVER PLACE	000000888S	SERVICE DATES	10/01/16	THROUGH	09/30/17
BRASELTON,GA 30517-5600		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,769.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,711.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	727.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,442.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,383.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,341.00	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	33,383.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,383.00	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

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER 000000899A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,452,441.95	ADJUSTMENTS	863,554.03
COVERED CHARGES	29,132,490.85	CONTRACTUAL ALLOW	22,288,565.01
NON-COVERD CHARGES	319,951.10	TOTAL MEDICAID LIAB	6,843,925.84
		LESS: COB	68,853.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,775,072.25

TOTAL NUMBER OF ADMISSIONS 1,091

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,918		0	3,709,104.00		56,942.00
ROUTINE NURSERY	949		0	1,332,360.00		120,853.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,867		0	5,041,464.00		177,795.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	480		0	1,413,940.00		0.00
NICU	63		0	268,513.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	543		0	1,682,453.00		0.00
TOTAL ACCOMODATIONS	4,410		0	6,723,917.00		177,795.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,017,478.58	0.00	OTHER LAB	100,380.00	0.00
MED/SURG SUPPLY	1,143,742.09	666.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,485,044.13	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	535,930.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,227,485.00	19,090.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	163,032.70	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	264,536.00	0.00	MRI SERVICES	408,235.00	0.00
IV THERAPY	377,753.00	0.00	PROFESSIONAL FEES	0.00	18.00
OPERATING ROOM	1,827,426.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,434,771.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,264,294.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,465.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	914,301.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	167,593.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	95,037.00	0.00	INJECTABLE DRUGS	634,606.55	0.00
RADIOLOGY THERAPEUTIC	145,145.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	36,322.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	42,053.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	282,957.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,635.00	0.00	TRAUMA RESPONSE	0.00	28,806.00
PSYCHIATRIC SERVICES	238,194.00	0.00	IMPL DEV CHARGE PATIENTS	336,761.30	0.00
LITHOTRIPSY	25,145.00	0.00	NO CC/INVALID REV CODE	0.00	50,646.00
OTHER IMAGING SERVICE	179,946.00	10,924.00			
BLOOD	104,136.00	0.00			
BLOOD STORAGE & PRO.	147,630.00	32,006.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	118,994.00	0.00			
AUDIOLOGY	56,878.00	0.00			
CARDIOLOGY	1,474,365.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,010.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,292.00	0.00			
			TOTAL ANCILLARY	22,408,573.85	142,156.10
			TOTAL ACCOMODATIONS	6,723,917.00	177,795.00
			TOTAL CHARGES	29,132,490.85	319,951.10

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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HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016299004222	10/12/16 - 10/17/16	10/31/16	0.00	6,565.00	0.00	0.00	0.00
614	2016324001259	10/06/16 - 10/26/16	11/28/16	0.00	6,275.00	0.00	0.00	0.00
614	2017054074796	01/20/17 - 02/13/17	02/27/17	0.00	5,740.00	0.00	0.00	0.00
614	2017055081951	02/14/17 - 02/16/17	02/27/17	0.00	6,900.00	0.00	0.00	0.00
614	2017089074084	03/14/17 - 03/20/17	04/03/17	0.00	5,970.00	0.00	0.00	0.00
614	2017137086225	04/27/17 - 05/01/17	05/22/17	0.00	6,275.00	0.00	0.00	0.00
614	2017254011815	09/03/17 - 09/05/17	09/18/17	0.00	6,894.00	0.00	0.00	0.00
614	2017321043751	08/16/17 - 08/23/17	11/20/17	0.00	6,027.00	0.00	0.00	0.00
TOTAL				0.00	50,646.00	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: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	470,215.55	ADJUSTMENTS	0.00
COVERED CHARGES	466,337.55	CONTRACTUAL ALLOW	195,977.12
NON-COVERD CHARGES	3,878.00	TOTAL MEDICAID LIAB	270,360.43
		LESS: COB	270,360.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	17		0	21,864.00		328.00
ROUTINE NURSERY	67		0	172,580.00		3,550.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	84		0	194,444.00		3,878.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	8,682.00		0.00
NICU	12		0	53,220.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	61,902.00		0.00
TOTAL ACCOMODATIONS	99		0	256,346.00		3,878.00

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

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

Run Date: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,327.85	0.00	OTHER LAB	1,425.00	0.00
MED/SURG SUPPLY	16,143.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,409.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,192.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,360.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,092.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,080.00	0.00	MRI SERVICES	5,780.00	0.00
IV THERAPY	782.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,519.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,318.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,176.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,405.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	224.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	549.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	188.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,843.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,434.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	432.00	0.00			
CARDIOLOGY	8,842.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,470.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	209,991.55	0.00
			TOTAL ACCOMODATIONS	256,346.00	3,878.00
			TOTAL CHARGES	466,337.55	3,878.00

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: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,201,090.32	ADJUSTMENTS	698,887.11
COVERED CHARGES	25,241,696.68	CONTRACTUAL ALLOW	21,715,569.24
NON-COVERD CHARGES	959,393.64	TOTAL MEDICAID LIAB	3,526,127.44
		LESS: COB	2,191.05
		LESS: COPAYMENT	7,677.48
		REIMBURSEMENT	3,516,258.91
		ALL OTHER	2,906,250.17
		FEE SCHEDULE-LAB	334,928.64
		INJECTABLE DRUGS	275,080.10

TOTAL NUMBER OF CLAIMS 8,164

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	542,924.03	2,139.90	OTHER LAB	572,902.00	2,749.00
MED/SURG SUPPLY	756,355.23	3,923.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	305.00	EDUCATION & TRAINING	5,062.00	1,936.00
RADIOLOGY-DIAGNOSTIC	1,342,151.00	23,126.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,663,695.00	111,818.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,951.00	9,613.14	FEE SCHEDULE LAB	5,837,242.47	144,844.70
EKG/ECG	431,206.00	720.00	MRI SERVICES	1,026,512.00	64,207.00
IV THERAPY	1,494,570.00	76,184.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,278,288.32	128,555.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,735.00	2,871.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	292,776.00	71,241.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	146,174.00	365.00	AMBULANCE	0.00	0.00
GI SERVICES	4,921.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,693,052.80	3,198.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,152.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	935,891.25	13,447.25
RADIOLOGY THERAPEUTIC	983,390.00	28,901.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,343.00	1,969.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	709.00	545.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,690.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,573.00	2,819.00	TRAUMA RESPONSE	0.00	21,316.00
PSYCHIATRIC SERVICES	10,311.00	15,649.00	IMPL DEV CHARGE PATIENTS	24,948.58	1,050.00
LITHOTRIPSY	26,403.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	800,307.00	151,942.00			
BLOOD	40,530.00	0.00			
BLOOD STORAGE & PRO.	30,512.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	318,557.00	11,621.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	755,009.00	26,858.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	438,994.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	588,549.00	27,789.00			
			TOTAL ANCILLARY	25,241,696.68	959,393.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,241,696.68	959,393.64

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: 08/28/2018
Run Time: 23:24:14
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	605,056.99	ADJUSTMENTS	0.00
COVERED CHARGES	564,786.87	CONTRACTUAL ALLOW	280,667.51
NON-COVERD CHARGES	40,270.12	TOTAL MEDICAID LIAB	284,119.36
		LESS: COB	284,020.36
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 160

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,160.34	0.00	OTHER LAB	4,283.00	0.00
MED/SURG SUPPLY	23,405.47	36.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	620.00	0.00
RADIOLOGY-DIAGNOSTIC	20,945.00	3,035.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	49,761.00	6,573.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	138,715.60	4,671.00
EKG/ECG	6,948.00	0.00	MRI SERVICES	12,839.00	0.00
IV THERAPY	41,781.00	1,088.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	48,064.33	12,004.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	810.00	1,852.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,612.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,952.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,109.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,085.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,054.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,288.90	4,201.45
RADIOLOGY THERAPEUTIC	2,558.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	183.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	779.23	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,161.00	5,820.00			
BLOOD	3,794.00	0.00			
BLOOD STORAGE & PRO.	1,756.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,620.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,431.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,144.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,932.00	806.00			
			TOTAL ANCILLARY	564,786.87	40,270.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	564,786.87	40,270.12

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

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

Run Date: 08/28/2018
Run Time: 23:24:18
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	439,754.92	ADJUSTMENTS	388.58
COVERED CHARGES	429,901.89	CONTRACTUAL ALLOW	412,896.13
NON-COVERD CHARGES	9,853.03	TOTAL MEDICAID LIAB	17,005.76
		LESS: COB	0.00
		LESS: COPAYMENT	585.00
		REIMBURSEMENT	16,420.76
		TOTAL NUMBER OF CLAIMS	304

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,597.10	0.00	OTHER LAB	1,251.00	0.00
MED/SURG SUPPLY	5,479.79	16.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,794.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,194.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	100,820.00	3,657.00
EKG/ECG	6,174.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,176.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,625.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	826.00	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	206,750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,994.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	232.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,285.00	6,180.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	429,901.89	9,853.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	429,901.89	9,853.03

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,914.22	ADJUSTMENTS	0.00
COVERED CHARGES	24,072.22	CONTRACTUAL ALLOW	10,528.20
NON-COVERD CHARGES	2,842.00	TOTAL MEDICAID LIAB	13,544.02
		LESS: COB	13,532.02
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	493.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	287.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,647.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,546.00	402.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,922.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	230.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	356.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,248.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,343.00	2,440.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,072.22	2,842.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,072.22	2,842.00

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,607,423.94	ADJUSTMENTS	77,321.22
COVERED CHARGES	4,502,162.22	CONTRACTUAL ALLOW	4,036,362.90
NON-COVERD CHARGES	105,261.72	TOTAL MEDICAID LIAB	465,799.32
		LESS: COB	0.00
		LESS: COPAYMENT	678.00
		REIMBURSEMENT	465,121.32

TOTAL NUMBER OF CLAIMS 84

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,092.19	0.00	OTHER LAB	0.00	130.00
MED/SURG SUPPLY	157,481.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,911.00	14,501.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,594.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	373.00	FEE SCHEDULE LAB	127,976.00	2,515.00
EKG/ECG	17,262.00	0.00	MRI SERVICES	0.00	6,069.00
IV THERAPY	71,734.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	805,361.00	4,227.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,040.00	1,239.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,229.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,329.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,755.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,682,965.74	20,381.70
RADIOLOGY THERAPEUTIC	465,783.00	8,896.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	889.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,690.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	267.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,186.00	0.00	IMPL DEV CHARGE PATIENTS	493,178.51	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,810.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	533,912.00	32,522.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,544.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,751.00	5,829.00			
			TOTAL ANCILLARY	4,502,162.22	105,261.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,502,162.22	105,261.72

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

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON,GA 30720-2529

PROVIDER NUMBER
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,343.32	ADJUSTMENTS	0.00
COVERED CHARGES	47,380.52	CONTRACTUAL ALLOW	25,864.15
NON-COVERD CHARGES	962.80	TOTAL MEDICAID LIAB	21,516.37
		LESS: COB	21,510.37
		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

HAMILTON MEDICAL CENTER
 1200 MEMORIAL DR
 DALTON,GA 30720-2529

PROVIDER NUMBER
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,663.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,654.00	48.00
EKG/ECG	720.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	281.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	122.00	914.80
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	11,040.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	26,520.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	47,380.52	962.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,380.52	962.80

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

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

Run Date: 08/28/2018
 Run Time: 23:34:51
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,560,874.02	ADJUSTMENTS	1,433,267.04
COVERED CHARGES	26,605,284.02	CONTRACTUAL ALLOW	21,515,297.61
NON-COVERD CHARGES	955,590.00	TOTAL MEDICAID LIAB	5,089,986.41
		LESS: COB	19,973.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,070,012.69

TOTAL NUMBER OF ADMISSIONS 749

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,965		0	2,242,726.00		544,044.00
ROUTINE NURSERY	676		0	836,903.00		115,725.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,641		0	3,079,629.00		659,769.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	336		0	1,411,326.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	336		0	1,411,326.00		0.00
TOTAL ACCOMODATIONS	2,977		0	4,490,955.00		659,769.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,935,346.00	17,504.00	OTHER LAB	88,671.00	0.00
MED/SURG SUPPLY	1,191,941.50	6,958.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,662,444.94	19,667.00	EDUCATION & TRAINING	2,756.00	0.00
RADIOLOGY-DIAGNOSTIC	362,298.00	0.00	OTHER THERAPEUTIC SVC	0.00	13,986.00
CT SCAN	1,007,974.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	162,756.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	120,315.00	0.00	MRI SERVICES	305,629.00	0.00
IV THERAPY	107,417.00	14,239.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,343,290.00	20,289.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	874,379.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,517,281.00	3,347.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	318,172.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	616,189.00	3,758.00	SPECIAL SERVICES	0.00	32,451.00
RECOVERY ROOM	218,015.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	65,959.00
LABORATORY PATHOLOGIC	228,888.00	0.00	INJECTABLE DRUGS	4,695,221.50	0.00
RADIOLOGY THERAPEUTIC	307,029.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	69,347.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	89,590.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	242,550.00	8,836.00	PATIENT CONVENIENCE	0.00	621.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	350.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	419.00	0.00	IMPL DEV CHARGE PATIENTS	466,934.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	174,666.00	49,421.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	271,792.00	15,117.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,426.08	20,194.00			
AUDIOLOGY	100,457.00	0.00			
CARDIOLOGY	517,683.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,496.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,956.00	3,124.00			
			TOTAL ANCILLARY	22,114,329.02	295,821.00
			TOTAL ACCOMODATIONS	4,490,955.00	659,769.00
			TOTAL CHARGES	26,605,284.02	955,590.00

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

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

Run Date: 08/28/2018
 Run Time: 23:35:07
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	227,924.50	ADJUSTMENTS	0.00
COVERED CHARGES	220,088.50	CONTRACTUAL ALLOW	141,514.50
NON-COVERD CHARGES	7,836.00	TOTAL MEDICAID LIAB	78,574.00
		LESS: COB	78,574.00
		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	32		0	36,092.00		5,705.00
ROUTINE NURSERY	1		0	4,494.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	33		0	40,586.00		5,705.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	33		0	40,586.00		5,705.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,499.00	0.00	OTHER LAB	1,329.00	0.00
MED/SURG SUPPLY	7,973.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	39,796.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,683.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	700.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,369.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,979.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,822.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,241.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,231.00	0.00	SPECIAL SERVICES	0.00	2,131.00
RECOVERY ROOM	2,354.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	673.00	0.00	INJECTABLE DRUGS	16,121.50	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	2,732.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	179,502.50	2,131.00
			TOTAL ACCOMODATIONS	40,586.00	5,705.00
			TOTAL CHARGES	220,088.50	7,836.00

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: 08/28/2018
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Page: 5

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,556,628.56	ADJUSTMENTS	814,726.26
COVERED CHARGES	16,108,178.06	CONTRACTUAL ALLOW	13,876,448.80
NON-COVERD CHARGES	1,448,450.50	TOTAL MEDICAID LIAB	2,231,729.26
		LESS: COB	11,052.60
		LESS: COPAYMENT	3,908.27
		REIMBURSEMENT	2,216,768.39
		ALL OTHER	1,765,387.86
		FEE SCHEDULE-LAB	141,801.61
		INJECTABLE DRUGS	309,578.92

TOTAL NUMBER OF CLAIMS 3,055

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	347,355.50	6,681.00	OTHER LAB	116,233.00	0.00
MED/SURG SUPPLY	387,813.00	5,777.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	278.00	0.00
RADIOLOGY-DIAGNOSTIC	480,591.00	5,242.00	OTHER THERAPEUTIC SVC	0.00	742.00
CT SCAN	2,242,778.00	199,019.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	58,370.00	15,425.00	FEE SCHEDULE LAB	2,309,902.16	55,474.00
EKG/ECG	191,540.00	1,400.00	MRI SERVICES	492,878.00	66,228.00
IV THERAPY	444,576.00	12,791.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,001,941.00	101,125.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	51,148.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,771.00	489.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	234,958.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,185,850.00	72,258.00	SPECIAL SERVICES	0.00	1,722.00
RECOVERY ROOM	204,737.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,452.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,522,211.50	697,510.00
RADIOLOGY THERAPEUTIC	597,054.00	5,402.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,738.00	2,052.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,286.00	4,142.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	14,700.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41,888.00	4,955.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,095.00	2,514.00	IMPL DEV CHARGE PATIENTS	91,695.00	3,230.00
LITHOTRIPSY	66,720.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	588,449.00	111,068.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,770.00	1,823.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	98,417.00	7,139.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	77,304.00	41,354.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	856.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,974.90	3,736.00			
			TOTAL ANCILLARY	16,108,178.06	1,448,450.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,108,178.06	1,448,450.50

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

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

Run Date: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	501,952.00	ADJUSTMENTS	0.00
COVERED CHARGES	334,739.50	CONTRACTUAL ALLOW	184,276.40
NON-COVERD CHARGES	167,212.50	TOTAL MEDICAID LIAB	150,463.10
		LESS: COB	150,379.90
		LESS: COPAYMENT	83.20
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,123.00	25.50	OTHER LAB	2,171.00	0.00
MED/SURG SUPPLY	18,513.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,386.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,017.00	51,811.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	433.00	FEE SCHEDULE LAB	69,405.00	7,340.00
EKG/ECG	2,800.00	0.00	MRI SERVICES	9,746.00	5,025.00
IV THERAPY	5,196.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,931.00	34,167.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,632.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	470.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,458.00	870.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	91,394.00	3,525.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,021.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,369.50	44,339.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	433.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	762.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	525.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	419.00	859.00	IMPL DEV CHARGE PATIENTS	4,494.00	3,100.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,211.00	13,752.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	771.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,458.00	0.00			
			TOTAL ANCILLARY	334,739.50	167,212.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	334,739.50	167,212.50

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: 08/28/2018
Run Time: 23:35:48
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	635,157.50	ADJUSTMENTS	960.67
COVERED CHARGES	600,185.50	CONTRACTUAL ALLOW	586,368.32
NON-COVERD CHARGES	34,972.00	TOTAL MEDICAID LIAB	13,817.18
		LESS: COB	20.25
		LESS: COPAYMENT	339.55
		REIMBURSEMENT	13,457.38

TOTAL NUMBER OF CLAIMS 247

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,541.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,652.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,400.00	1,080.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,801.00	18,259.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	133,986.00	2,008.00
EKG/ECG	8,750.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,162.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,170.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	289,218.00	5,842.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,674.00	860.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	838.00	419.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,851.00	6,504.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142.00	0.00			
			TOTAL ANCILLARY	600,185.50	34,972.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	600,185.50	34,972.00

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC
450 NORTHSIDE CHEROKEE BLVD
CANTON,GA 30115-8015

PROVIDER NUMBER 000001108A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,260.00	ADJUSTMENTS	0.00
COVERED CHARGES	18,496.50	CONTRACTUAL ALLOW	10,185.33
NON-COVERD CHARGES	3,763.50	TOTAL MEDICAID LIAB	8,311.17
		LESS: COB	8,305.17
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	898.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	539.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	927.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,346.00	1,081.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,150.00	1,174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	636.00	1,089.50
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	419.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,496.50	3,763.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,496.50	3,763.50

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	989,803.11	ADJUSTMENTS	21,753.40
COVERED CHARGES	957,734.11	CONTRACTUAL ALLOW	848,922.11
NON-COVERD CHARGES	32,069.00	TOTAL MEDICAID LIAB	108,812.00
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	108,755.00
		TOTAL NUMBER OF CLAIMS	20

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,999.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	54,739.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,026.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,979.00	387.00
EKG/ECG	4,200.00	0.00	MRI SERVICES	5,025.00	0.00
IV THERAPY	26,708.00	186.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	165,612.00	2.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,359.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,324.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,825.00	422.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,024.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	423,945.00	15,092.00
RADIOLOGY THERAPEUTIC	1,455.00	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	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	875.00	175.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	123,247.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,139.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	41,731.00	15,805.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,521.61	0.00			
			TOTAL ANCILLARY	957,734.11	32,069.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	957,734.11	32,069.00

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

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

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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	10/01/16	THROUGH	09/30/17
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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER 000001229A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,633,563.60	ADJUSTMENTS	73,923.35
COVERED CHARGES	5,611,451.60	CONTRACTUAL ALLOW	3,769,405.22
NON-COVERD CHARGES	22,112.00	TOTAL MEDICAID LIAB	1,842,046.38
		LESS: COB	16,745.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,825,300.44

TOTAL NUMBER OF ADMISSIONS 192

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	625		0	533,520.00		1,026.00
ROUTINE NURSERY	38		0	27,015.00		4,600.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	663		0	560,535.00		5,626.00
SPECIAL CARE SERVICES						
CCU	321		0	355,670.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	321		0	355,670.00		0.00
TOTAL ACCOMODATIONS	984		0	916,205.00		5,626.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	882,766.44	0.00	OTHER LAB	22,411.00	0.00
MED/SURG SUPPLY	312,656.49	227.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	415,752.00	0.00	EDUCATION & TRAINING	2,534.00	0.00
RADIOLOGY-DIAGNOSTIC	63,733.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	177,182.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	55,716.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	41,748.00	0.00	MRI SERVICES	67,354.00	0.00
IV THERAPY	108,512.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	303,402.45	8,130.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,553.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,074,297.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,714.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	34,719.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	270,519.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,645.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	10,798.00	0.00	INJECTABLE DRUGS	7,705.40	0.00
RADIOLOGY THERAPEUTIC	5,440.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,970.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,900.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	94,310.90	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,631.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	106,490.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,712.00	4,498.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	136,323.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	31,775.00	0.00			
AUDIOLOGY	2,560.00	0.00			
CARDIOLOGY	278,466.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,966.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	70,613.00	0.00			
			TOTAL ANCILLARY	4,695,246.60	16,486.00
			TOTAL ACCOMODATIONS	916,205.00	5,626.00
			TOTAL CHARGES	5,611,451.60	22,112.00

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

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

Run Date: 08/28/2018
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,237.32	ADJUSTMENTS	0.00
COVERED CHARGES	9,237.32	CONTRACTUAL ALLOW	5,078.44
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,158.88
		LESS: COB	4,158.88
		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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,029.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	497.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,598.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,225.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	148.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,030.00	0.00			
			TOTAL ANCILLARY	7,527.32	0.00
			TOTAL ACCOMODATIONS	1,710.00	0.00
			TOTAL CHARGES	9,237.32	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: 08/28/2018
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SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,893,944.96	ADJUSTMENTS	152,533.92
COVERED CHARGES	4,625,943.43	CONTRACTUAL ALLOW	3,472,343.86
NON-COVERD CHARGES	268,001.53	TOTAL MEDICAID LIAB	1,153,599.57
		LESS: COB	371.37
		LESS: COPAYMENT	3,174.00
		REIMBURSEMENT	1,150,054.20
		ALL OTHER	816,762.92
		FEE SCHEDULE-LAB	96,941.82
		INJECTABLE DRUGS	236,349.46

TOTAL NUMBER OF CLAIMS 2,450

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	186,284.30	0.00	OTHER LAB	149,806.00	0.00
MED/SURG SUPPLY	197,688.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125,745.00	5,379.00	OTHER THERAPEUTIC SVC	0.00	274.00
CT SCAN	371,079.00	28,774.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,375.00	1,193.00	FEE SCHEDULE LAB	448,572.00	20,234.00
EKG/ECG	51,699.00	784.00	MRI SERVICES	101,114.00	12,106.00
IV THERAPY	314,473.00	2,447.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	325,754.05	18,742.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,862.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	91,703.00	32,188.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,633.00	289.00	AMBULANCE	0.00	0.00
GI SERVICES	159,062.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	622,241.00	1,953.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	50,406.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	737,364.12	87,546.93
RADIOLOGY THERAPEUTIC	14,508.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,954.00	339.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,456.00	213.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	52,017.00	2,660.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,994.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	203,955.00	9,109.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,579.00	106.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	79,572.00	7,760.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	135,844.00	35,673.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	78,203.00	231.00			
			TOTAL ANCILLARY	4,625,943.43	268,001.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,625,943.43	268,001.53

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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,181.61	ADJUSTMENTS	0.00
COVERED CHARGES	38,707.61	CONTRACTUAL ALLOW	14,985.74
NON-COVERD CHARGES	11,474.00	TOTAL MEDICAID LIAB	23,721.87
		LESS: COB	23,688.87
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,925.00	0.00	OTHER LAB	461.00	0.00
MED/SURG SUPPLY	2,337.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	608.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,336.00	4,433.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,429.00	568.00
EKG/ECG	588.00	0.00	MRI SERVICES	2,272.00	0.00
IV THERAPY	9,054.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,801.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,657.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,317.00	140.00
RADIOLOGY THERAPEUTIC	548.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,448.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,084.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,707.61	11,474.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,707.61	11,474.00

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: 08/28/2018
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SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	267,422.02	ADJUSTMENTS	399.52
COVERED CHARGES	258,053.02	CONTRACTUAL ALLOW	246,417.50
NON-COVERD CHARGES	9,369.00	TOTAL MEDICAID LIAB	11,635.52
		LESS: COB	0.00
		LESS: COPAYMENT	498.55
		REIMBURSEMENT	11,136.97
		TOTAL NUMBER OF CLAIMS	208

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,760.82	0.00	OTHER LAB	3,072.00	0.00
MED/SURG SUPPLY	11,207.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,181.00	517.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,941.00	6,498.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,418.00	0.00	FEE SCHEDULE LAB	28,347.00	888.00
EKG/ECG	3,920.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,177.00	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	3,212.00	448.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	132,920.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,932.19	891.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	127.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,417.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	548.00	0.00			
			TOTAL ANCILLARY	258,053.02	9,369.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	258,053.02	9,369.00

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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SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,931.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,917.00	CONTRACTUAL ALLOW	1,457.26
NON-COVERD CHARGES	14.00	TOTAL MEDICAID LIAB	1,459.74
		LESS: COB	1,453.74
		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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	76.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	599.00	14.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	127.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,046.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,917.00	14.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,917.00	14.00

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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	895,619.70	ADJUSTMENTS	39,871.05
COVERED CHARGES	886,758.70	CONTRACTUAL ALLOW	692,953.60
NON-COVERD CHARGES	8,861.00	TOTAL MEDICAID LIAB	193,805.10
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	193,691.10

TOTAL NUMBER OF CLAIMS 34

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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,630.45	0.00	OTHER LAB	768.00	0.00
MED/SURG SUPPLY	21,643.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	38.00	0.00
RADIOLOGY-DIAGNOSTIC	17,040.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,244.00	0.00
EKG/ECG	1,764.00	392.00	MRI SERVICES	0.00	0.00
IV THERAPY	35,991.00	554.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,331.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,042.00	1,344.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,766.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,562.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	511,460.00	6,571.00
RADIOLOGY THERAPEUTIC	2,974.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	41,216.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,692.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	176,033.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,564.00	0.00			
			TOTAL ANCILLARY	886,758.70	8,861.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	886,758.70	8,861.00

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: 08/28/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	04/30/17
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: 08/28/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER 000001229A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,000,452.60	ADJUSTMENTS	512,399.85
COVERED CHARGES	11,550,610.57	CONTRACTUAL ALLOW	8,380,181.03
NON-COVERD CHARGES	449,842.03	TOTAL MEDICAID LIAB	3,170,429.54
		LESS: COB	11,915.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,158,513.61

TOTAL NUMBER OF ADMISSIONS 316

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,130		0	960,746.50		285,357.00
ROUTINE NURSERY	42		0	29,806.00		7,231.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,172		0	990,552.50		292,588.00
SPECIAL CARE SERVICES						
CCU	309		0	353,437.50		0.00
ICU	274		0	558,003.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	583		0	911,440.50		0.00
TOTAL ACCOMODATIONS	1,755		0	1,901,993.00		292,588.00

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

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

Run Date: 08/28/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	307,658.47	2,938.00	OTHER LAB	60,713.90	0.00
MED/SURG SUPPLY	514,612.97	2,040.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	906,043.96	782.60	EDUCATION & TRAINING	988.00	0.00
RADIOLOGY-DIAGNOSTIC	153,798.06	0.00	OTHER THERAPEUTIC SVC	0.00	18,673.20
CT SCAN	357,584.50	27,105.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,427.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	87,358.90	0.00	MRI SERVICES	109,764.20	0.00
IV THERAPY	79,989.60	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	426,244.00	3,364.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,240.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,157,041.59	2,849.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	200,391.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	87,606.40	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	689,061.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,883.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	25,283.00	0.00	INJECTABLE DRUGS	1,327,361.22	0.00
RADIOLOGY THERAPEUTIC	2,821.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	15,888.95	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,252.86	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	32,329.70	24,869.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,736.00	17,218.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	82,467.63	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	93,858.70	5,847.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,192.00	50,768.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,095.70	440.70			
AUDIOLOGY	6,156.80	0.00			
CARDIOLOGY	568,913.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,991.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	88,860.30	356.20			
			TOTAL ANCILLARY	9,648,617.57	157,254.03
			TOTAL ACCOMODATIONS	1,901,993.00	292,588.00
			TOTAL CHARGES	11,550,610.57	449,842.03

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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/17	THROUGH	12/31/17
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: 08/28/2018
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SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,070,717.79	ADJUSTMENTS	6,723.97
COVERED CHARGES	6,703,103.19	CONTRACTUAL ALLOW	5,214,654.88
NON-COVERD CHARGES	1,367,614.60	TOTAL MEDICAID LIAB	1,488,448.31
		LESS: COB	1,032.41
		LESS: COPAYMENT	4,803.92
		REIMBURSEMENT	1,482,611.98
		ALL OTHER	1,292,666.73
		FEE SCHEDULE-LAB	126,137.87
		INJECTABLE DRUGS	63,807.38
		TOTAL NUMBER OF CLAIMS	3,756

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,024.03	4,834.73	OTHER LAB	67,548.00	0.00
MED/SURG SUPPLY	183,634.93	848.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	254,065.50	52,617.50	OTHER THERAPEUTIC SVC	0.00	356.20
CT SCAN	381,343.30	350,556.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,332.40	3,952.00	FEE SCHEDULE LAB	847,100.85	84,904.07
EKG/ECG	113,034.80	0.00	MRI SERVICES	135,995.60	19,585.80
IV THERAPY	507,519.20	36,298.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	454,414.46	105,923.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,295.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	148,221.10	2,137.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	359,222.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	338,634.60	69,606.10	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,340,215.72	15,036.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	83,337.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	294,609.31	281,593.06
RADIOLOGY THERAPEUTIC	16,673.80	30,560.40	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,812.70	3,426.80	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	971.10	655.20	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,486.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	128,868.30	30,578.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,435.19	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	253,394.40	65,048.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,088.10	12,249.90			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	96,621.20	61,676.80			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	166,507.90	127,407.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	176,543.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	104,637.70	5,274.10			
			TOTAL ANCILLARY	6,703,103.19	1,367,614.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,703,103.19	1,367,614.60

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,717.97	ADJUSTMENTS	0.00
COVERED CHARGES	40,846.58	CONTRACTUAL ALLOW	19,845.97
NON-COVERD CHARGES	5,871.39	TOTAL MEDICAID LIAB	21,000.61
		LESS: COB	20,984.97
		LESS: COPAYMENT	15.64
		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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,363.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,106.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	513.50	553.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,118.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,134.00	520.00
EKG/ECG	509.60	254.80	MRI SERVICES	2,145.00	0.00
IV THERAPY	2,867.80	379.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,633.50	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	6,195.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,149.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,085.10	347.69	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,059.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85.80	299.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	397.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	998.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	40,846.58	5,871.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,846.58	5,871.39

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

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

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SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	741,465.53	ADJUSTMENTS	158.82
COVERED CHARGES	616,394.24	CONTRACTUAL ALLOW	592,563.80
NON-COVERD CHARGES	125,071.29	TOTAL MEDICAID LIAB	23,830.44
		LESS: COB	0.00
		LESS: COPAYMENT	915.00
		REIMBURSEMENT	22,915.44
		TOTAL NUMBER OF CLAIMS	426

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,405.91	232.30	OTHER LAB	5,691.40	0.00
MED/SURG SUPPLY	7,823.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,612.60	15,203.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,664.20	96,609.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	78,654.50	5,565.30
EKG/ECG	11,720.80	0.00	MRI SERVICES	8,860.80	0.00
IV THERAPY	45,020.00	1,006.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,093.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,954.00	356.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	376,432.58	584.99	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,706.22	0.00
RADIOLOGY THERAPEUTIC	165.10	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	617.50	617.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,942.00	4,895.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	616,394.24	125,071.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	616,394.24	125,071.29

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 SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,167.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,125.80	CONTRACTUAL ALLOW	589.91
NON-COVERD CHARGES	41.60	TOTAL MEDICAID LIAB	535.89
		LESS: COB	535.89
		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
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/28/2018
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	466.70	41.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	659.10	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	1,125.80	41.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,125.80	41.60

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: 08/28/2018
Run Time: 23:27:45
Page: 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,630,703.83	ADJUSTMENTS	0.00
COVERED CHARGES	1,622,384.55	CONTRACTUAL ALLOW	1,388,678.40
NON-COVERD CHARGES	8,319.28	TOTAL MEDICAID LIAB	233,706.15
		LESS: COB	0.00
		LESS: COPAYMENT	153.00
		REIMBURSEMENT	233,553.15
		TOTAL NUMBER OF CLAIMS	41

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

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
 1900 TEBEAU ST
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,601.17	284.38	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	48,092.02	1,900.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	513.50	236.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,112.40	742.30
EKG/ECG	4,076.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,098.90	3,796.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,205.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,271.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,645.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,895.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,679.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,181,680.68	0.00
RADIOLOGY THERAPEUTIC	2,146.30	1,080.30	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	279.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,066.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,849.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,809.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	159,377.40	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	11,263.30	0.00			
			TOTAL ANCILLARY	1,622,384.55	8,319.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,622,384.55	8,319.28

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

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

Run Date: 08/28/2018
Run Time: 23:27:46
Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SERVICES, LLC
1900 TEBEAU ST
WAYCROSS,GA 31501-6357

PROVIDER NUMBER
000001229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/17	THROUGH	12/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER 000001394A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,960,625.24	ADJUSTMENTS	81,539.60
COVERED CHARGES	9,688,340.24	CONTRACTUAL ALLOW	6,527,292.52
NON-COVERD CHARGES	272,285.00	TOTAL MEDICAID LIAB	3,161,047.72
		LESS: COB	32,534.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,128,513.72

TOTAL NUMBER OF ADMISSIONS 413

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,087		0	688,071.00		44,621.00
ROUTINE NURSERY	181		0	181,415.00		133,494.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,268		0	869,486.00		178,115.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	181		0	277,835.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	181		0	277,835.00		0.00
TOTAL ACCOMODATIONS	1,449		0	1,147,321.00		178,115.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,765,202.82	0.00	OTHER LAB	44,321.00	0.00
MED/SURG SUPPLY	266,791.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,464,218.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110,614.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	722,093.00	5,721.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	133,170.32	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	57,288.00	0.00	MRI SERVICES	117,522.00	0.00
IV THERAPY	1,782.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	788,264.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	165,620.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	525,574.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	113,344.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	188,487.00	1,756.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	506,896.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	182,222.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,990.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,929.35	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	173,514.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,840.00	1,256.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	356,300.63	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	90,273.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	197,468.00	52,983.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	123,407.00	32,454.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	272,692.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,620.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	110,576.00	0.00			
			TOTAL ANCILLARY	8,541,019.24	94,170.00
			TOTAL ACCOMODATIONS	1,147,321.00	178,115.00
			TOTAL CHARGES	9,688,340.24	272,285.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,438.75	ADJUSTMENTS	0.00
COVERED CHARGES	79,190.75	CONTRACTUAL ALLOW	47,275.34
NON-COVERD CHARGES	248.00	TOTAL MEDICAID LIAB	31,915.41
		LESS: COB	31,915.41
		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	8		0	5,064.00		248.00
ROUTINE NURSERY	4		0	2,488.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	7,552.00		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	12		0	7,552.00		248.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,662.38	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,521.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,227.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	175.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,810.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	558.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,454.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,493.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,361.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,260.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,308.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,079.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	221.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	779.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	730.00	0.00			
			TOTAL ANCILLARY	71,638.75	0.00
			TOTAL ACCOMODATIONS	7,552.00	248.00
			TOTAL CHARGES	79,190.75	248.00

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: 08/28/2018
Run Time: 23:42:47
Page: 5

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,689,729.02	ADJUSTMENTS	278,184.20
COVERED CHARGES	8,199,059.26	CONTRACTUAL ALLOW	6,690,302.60
NON-COVERD CHARGES	1,490,669.76	TOTAL MEDICAID LIAB	1,508,756.66
		LESS: COB	14,100.32
		LESS: COPAYMENT	2,631.00
		REIMBURSEMENT	1,492,025.34
		ALL OTHER	1,342,140.25
		FEE SCHEDULE-LAB	120,712.99
		INJECTABLE DRUGS	29,172.10

TOTAL NUMBER OF CLAIMS 3,338

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	228,406.13	7,072.00	OTHER LAB	78,376.00	2,297.00
MED/SURG SUPPLY	139,175.40	7,432.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	322,111.00	27,473.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,519,867.00	382,847.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,743.00	18,761.68	FEE SCHEDULE LAB	1,533,973.50	57,863.00
EKG/ECG	93,071.00	4,464.00	MRI SERVICES	157,793.00	55,311.00
IV THERAPY	37,732.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	579,922.00	204,859.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,609.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,266.00	125,851.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	130,811.00	2,025.00	AMBULANCE	0.00	0.00
GI SERVICES	30,433.00	10,788.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,913,060.00	80,647.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	241,368.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	280,955.87	94,133.84
RADIOLOGY THERAPEUTIC	4,564.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	450.00	4,270.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	47,322.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	54,382.00	10,166.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,678.66	21,189.06
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	200,497.00	44,563.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,239.00	14,616.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	149,731.00	166,001.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	83,749.00	97,315.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	92,963.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	185,132.70	3,403.00			
			TOTAL ANCILLARY	8,199,059.26	1,490,669.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,199,059.26	1,490,669.76

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

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

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

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,929.33	ADJUSTMENTS	0.00
COVERED CHARGES	79,879.85	CONTRACTUAL ALLOW	49,132.27
NON-COVERD CHARGES	30,049.48	TOTAL MEDICAID LIAB	30,747.58
		LESS: COB	30,729.18
		LESS: COPAYMENT	18.40
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

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

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,121.34	0.00	OTHER LAB	276.00	0.00
MED/SURG SUPPLY	865.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,161.00	820.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,017.00	23,599.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,873.00	1,268.00
EKG/ECG	744.00	0.00	MRI SERVICES	5,406.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,568.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,489.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,945.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,620.00	1,052.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,609.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,369.51	575.48
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	1,032.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,304.00	2,735.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,861.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,664.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	955.00	0.00			
			TOTAL ANCILLARY	79,879.85	30,049.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,879.85	30,049.48

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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	301,936.57	ADJUSTMENTS	429.52
COVERED CHARGES	283,658.09	CONTRACTUAL ALLOW	269,309.33
NON-COVERD CHARGES	18,278.48	TOTAL MEDICAID LIAB	14,348.76
		LESS: COB	699.40
		LESS: COPAYMENT	420.84
		REIMBURSEMENT	13,228.52
		TOTAL NUMBER OF CLAIMS	244

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,325.91	83.20	OTHER LAB	1,097.00	0.00
MED/SURG SUPPLY	1,266.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,309.00	1,288.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,643.00	11,082.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,523.00	1,904.00
EKG/ECG	2,418.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	285.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,596.00	2,327.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,699.18	1,594.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,496.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	283,658.09	18,278.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	283,658.09	18,278.48

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,469.40	ADJUSTMENTS	0.00
COVERED CHARGES	8,220.74	CONTRACTUAL ALLOW	6,393.72
NON-COVERD CHARGES	12,248.66	TOTAL MEDICAID LIAB	1,827.02
		LESS: COB	1,815.02
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	331.00	240.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,810.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,379.00	39.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,628.00	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	716.34	58.66
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	779.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,220.74	12,248.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,220.74	12,248.66

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

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

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

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	518,365.85	ADJUSTMENTS	11,084.46
COVERED CHARGES	503,006.65	CONTRACTUAL ALLOW	408,450.84
NON-COVERD CHARGES	15,359.20	TOTAL MEDICAID LIAB	94,555.81
		LESS: COB	2,488.87
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	92,015.94

TOTAL NUMBER OF CLAIMS 17

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

PIEDMONT NEWTON HOSPITAL
 5126 HOSPITAL DR NE
 COVINGTON,GA 30014-2566

PROVIDER NUMBER
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,325.14	416.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,717.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	747.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,405.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	672.00	FEE SCHEDULE LAB	5,427.00	1,581.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	677.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	89,025.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,395.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	726.00	699.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,385.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	257,370.81	4,098.54
RADIOLOGY THERAPEUTIC	18,390.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	46,390.32	1,262.66
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	644.00	1,225.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,024.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,445.00	0.00			
			TOTAL ANCILLARY	503,006.65	15,359.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	503,006.65	15,359.20

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL
5126 HOSPITAL DR NE
COVINGTON,GA 30014-2566

PROVIDER NUMBER
000001394A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/28/2018
 Run Time: 23:31:43
 Page: 1

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,710,396.57	ADJUSTMENTS	3,423,056.67
COVERED CHARGES	73,582,871.96	CONTRACTUAL ALLOW	51,389,209.16
NON-COVERD CHARGES	2,127,524.61	TOTAL MEDICAID LIAB	22,193,662.80
		LESS: COB	160,095.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	22,033,567.57

TOTAL NUMBER OF ADMISSIONS 1,780

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9,066		2	5,829,530.00		621,474.00
ROUTINE NURSERY	862		0	622,853.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9,928		2	6,452,383.00		621,474.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,614		0	2,905,473.00		21,889.00
NICU	812		0	1,750,721.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,426		0	4,656,194.00		21,889.00
TOTAL ACCOMODATIONS	12,354		2	11,108,577.00		643,363.00

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,369,300.51	310,000.30	OTHER LAB	367,062.00	1,409.00
MED/SURG SUPPLY	7,044,621.04	148,950.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,486,046.29	69,513.00	EDUCATION & TRAINING	77.00	0.00
RADIOLOGY-DIAGNOSTIC	1,216,025.00	6,850.00	OTHER THERAPEUTIC SVC	0.00	12,664.00
CT SCAN	2,246,502.00	40,698.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	738,983.46	11,821.09	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	279,890.00	1,710.00	MRI SERVICES	558,040.00	0.00
IV THERAPY	674,433.00	8,143.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,402,736.00	80,822.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	212,315.09	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,392,559.25	55,309.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,576,914.00	121.00	AMBULANCE	0.00	0.00
GI SERVICES	268,613.00	1,806.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,027,259.00	2,569.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,139,935.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	162,871.00	0.00	INJECTABLE DRUGS	113,245.94	0.00
RADIOLOGY THERAPEUTIC	532,903.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	413,434.36	8,009.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	120,014.18	2,905.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	342.00	43,291.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	48,285.00	0.00	IMPL DEV CHARGE PATIENTS	3,767,533.84	2,075.43
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	27,416.00
OTHER IMAGING SERVICE	382,583.00	6,878.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	553,540.00	602,150.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	132,434.00	0.00			
AUDIOLOGY	62,640.00	0.00			
CARDIOLOGY	1,908,042.00	23,054.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,814.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,219,301.00	15,996.00			
			TOTAL ANCILLARY	62,474,294.96	1,484,161.61
			TOTAL ACCOMODATIONS	11,108,577.00	643,363.00
			TOTAL CHARGES	73,582,871.96	2,127,524.61

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: 08/28/2018
 Run Time: 23:31:43
 Page: 3

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016266102017	09/07/16 - 09/10/16	09/26/16	0.00	2,722.00	0.00	0.00	0.00
615	2316333000026	09/13/16 - 09/16/16	12/19/16	0.00	2,722.00	0.00	1,690.88	0.00
615	2216349000487	10/14/16 - 10/17/16	12/19/16	0.00	2,722.00	0.00	0.00	0.00
615	5217152000326	12/13/16 - 01/23/17	06/05/17	0.00	2,722.00	0.00	0.00	0.00
615	2017213085810	07/22/17 - 07/26/17	08/07/17	0.00	2,722.00	0.00	0.00	0.00
615	2017217027343	07/21/17 - 07/26/17	08/14/17	0.00	2,722.00	0.00	0.00	0.00
615	2117256000006	03/10/17 - 03/17/17	10/16/17	0.00	2,722.00	0.00	2,585.71	0.00
615	2317321000018	02/27/17 - 03/03/17	12/18/17	0.00	2,722.00	0.00	1,736.47	0.00
615	2218002000337	08/11/16 - 09/16/16	01/08/18	0.00	2,388.00	0.00	0.00	0.00
616	5918018020508	11/28/16 - 11/30/16	01/22/18	0.00	3,252.00	0.00	0.00	0.00
TOTAL				0.00	27,416.00	0.00	6,013.06	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: 08/28/2018
 Run Time: 23:32:25
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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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	436,245.99	ADJUSTMENTS	0.00
COVERED CHARGES	427,962.77	CONTRACTUAL ALLOW	123,808.38
NON-COVERD CHARGES	8,283.22	TOTAL MEDICAID LIAB	304,154.39
		LESS: COB	304,154.39
		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	61		0	39,955.00		2,860.00
ROUTINE NURSERY	13		0	9,112.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	74		0	49,067.00		2,860.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	5		0	9,625.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	9,625.00		0.00
TOTAL ACCOMODATIONS	79		0	58,692.00		2,860.00

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,125.95	0.00	OTHER LAB	1,137.00	0.00
MED/SURG SUPPLY	29,020.25	21.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,031.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,747.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,061.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,773.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	570.00	0.00	MRI SERVICES	20,378.00	0.00
IV THERAPY	4,244.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,955.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,346.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,555.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,842.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,259.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,046.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	890.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	7,610.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,747.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	568.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	490.00	0.00	IMPL DEV CHARGE PATIENTS	45,052.51	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,722.00
OTHER IMAGING SERVICE	5,524.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	660.00	1,978.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	439.00	0.00			
CARDIOLOGY	8,896.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	905.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,967.00	134.00			
			TOTAL ANCILLARY	369,270.77	5,423.22
			TOTAL ACCOMODATIONS	58,692.00	2,860.00
			TOTAL CHARGES	427,962.77	8,283.22

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: 08/28/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016299007739	09/02/16 - 09/06/16	10/31/16	0.00	2,722.00	0.00	18,197.40	0.00
TOTAL				0.00	2,722.00	0.00	18,197.40	0.00

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

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

Run Date: 08/28/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,924,636.70	ADJUSTMENTS	1,391,204.29
COVERED CHARGES	37,154,385.65	CONTRACTUAL ALLOW	28,958,993.26
NON-COVERD CHARGES	4,770,251.05	TOTAL MEDICAID LIAB	8,195,392.39
		LESS: COB	6,464.64
		LESS: COPAYMENT	29,613.40
		REIMBURSEMENT	8,159,314.35
		ALL OTHER	6,581,188.31
		FEE SCHEDULE-LAB	510,317.28
		INJECTABLE DRUGS	1,067,808.76
		TOTAL NUMBER OF CLAIMS	15,764

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,514,445.49	28,380.66	OTHER LAB	216,352.00	2,370.00
MED/SURG SUPPLY	2,013,186.84	10,894.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	165.00	EDUCATION & TRAINING	0.00	230.00
RADIOLOGY-DIAGNOSTIC	988,406.32	46,476.00	OTHER THERAPEUTIC SVC	0.00	1,328.00
CT SCAN	2,529,278.00	325,138.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	77,241.00	23,817.44	FEE SCHEDULE LAB	2,549,780.19	196,380.60
EKG/ECG	304,685.00	12,892.00	MRI SERVICES	733,440.00	63,258.00
IV THERAPY	1,325,825.00	78,640.69	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,611,855.37	787,543.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	41,440.00	0.00	REHAB THERAPY	0.00	3,104.00
RESPIRATORY SERVICES	243,510.00	67,743.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,080,702.00	3,839.00	AMBULANCE	0.00	0.00
GI SERVICES	892,921.50	109,279.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,892,400.00	114,634.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,606,052.00	3,032.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,718,878.40	1,975,775.16
RADIOLOGY THERAPEUTIC	2,483,545.00	390,398.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,893.00	8,877.16	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,291.04	12,595.64	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	723,648.00	60,609.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	26,429.00	73,010.00	IMPL DEV CHARGE PATIENTS	435,684.66	244.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,552.00
OTHER IMAGING SERVICE	918,608.81	65,252.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	145,979.00	100,808.00			
ONCOLOGY	166.00	422.00			
NUCLEAR MEDICINE	616,697.00	45,819.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	617,922.00	85,602.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	377,695.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	426,428.03	65,142.00			
			TOTAL ANCILLARY	37,154,385.65	4,770,251.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,154,385.65	4,770,251.05

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: 08/28/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017111087707	03/07/17 - 03/07/17	05/01/17	0.00	2,388.00	0.00	0.00	0.00
615	2017209010254	07/13/17 - 07/13/17	07/31/17	0.00	2,388.00	0.00	0.00	0.00
287	2217219002266	03/17/17 - 03/17/17	08/14/17	0.00	1,564.00	0.00	0.00	0.00
696	2217226004726	02/21/17 - 02/28/17	08/21/17	0.00	144.00	0.00	0.00	0.00
3001	2217272014485	09/06/16 - 09/06/16	10/02/17	0.00	68.00	0.00	0.00	0.00
TOTAL				0.00	6,552.00	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: 08/28/2018
Run Time: 23:34:27
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	577,724.17	ADJUSTMENTS	0.00
COVERED CHARGES	365,036.06	CONTRACTUAL ALLOW	56,640.54
NON-COVERD CHARGES	212,688.11	TOTAL MEDICAID LIAB	308,395.52
		LESS: COB	308,076.00
		LESS: COPAYMENT	319.52
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 247

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,708.97	22,485.17	OTHER LAB	2,596.00	0.00
MED/SURG SUPPLY	27,673.19	1,120.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,458.00	531.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,582.00	11,756.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	16,881.00	FEE SCHEDULE LAB	28,278.75	2,580.00
EKG/ECG	1,900.00	190.00	MRI SERVICES	4,026.00	0.00
IV THERAPY	13,924.00	976.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,992.00	38,628.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	525.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	460.00	10,820.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,522.00	1,325.00	AMBULANCE	0.00	0.00
GI SERVICES	9,030.00	1,806.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,438.00	204.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,522.00	3,753.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,432.53	8,919.06
RADIOLOGY THERAPEUTIC	14,129.00	1,840.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,930.00	342.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	14,557.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,849.00	2,707.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	980.00	IMPL DEV CHARGE PATIENTS	10,841.62	9,234.76
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,130.00	8,400.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,620.00	5,091.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,570.00	47,428.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,498.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,400.00	134.00			
			TOTAL ANCILLARY	365,036.06	212,688.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	365,036.06	212,688.11

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

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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	516,851.14	ADJUSTMENTS	379.58
COVERED CHARGES	479,819.67	CONTRACTUAL ALLOW	464,771.81
NON-COVERD CHARGES	37,031.47	TOTAL MEDICAID LIAB	15,047.86
		LESS: COB	0.00
		LESS: COPAYMENT	591.13
		REIMBURSEMENT	14,456.73
		TOTAL NUMBER OF CLAIMS	269

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,511.98	0.00	OTHER LAB	745.00	0.00
MED/SURG SUPPLY	28,574.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,445.00	437.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,110.00	6,916.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,461.00	3,046.00
EKG/ECG	6,262.00	380.00	MRI SERVICES	2,306.00	0.00
IV THERAPY	18,769.00	2,241.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,785.00	4,765.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	784.00	1,396.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,742.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	229,333.00	3,746.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,760.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,222.88	5,394.47
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	1,960.00	IMPL DEV CHARGE PATIENTS	3,446.02	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,534.00	3,631.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,210.00	989.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,273.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	782.00	2,068.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	825.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,938.00	62.00			
			TOTAL ANCILLARY	479,819.67	37,031.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	479,819.67	37,031.47

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

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

Run Date: 08/28/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,930.67	ADJUSTMENTS	0.00
COVERED CHARGES	7,661.97	CONTRACTUAL ALLOW	3,465.17
NON-COVERD CHARGES	268.70	TOTAL MEDICAID LIAB	4,196.80
		LESS: COB	4,190.80
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	177.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	718.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	762.00	50.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	213.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,599.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49.47	5.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,661.97	268.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,661.97	268.70

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

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

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

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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,509,780.39	ADJUSTMENTS	457,282.40
COVERED CHARGES	12,012,458.35	CONTRACTUAL ALLOW	10,355,962.64
NON-COVERD CHARGES	497,322.04	TOTAL MEDICAID LIAB	1,656,495.71
		LESS: COB	4,446.34
		LESS: COPAYMENT	1,435.18
		REIMBURSEMENT	1,650,614.19

TOTAL NUMBER OF CLAIMS 290

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233,289.69	392.00	OTHER LAB	1,113.00	0.00
MED/SURG SUPPLY	414,836.73	640.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,229.00	11,566.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,521.00	17,484.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	221.00	221.06	FEE SCHEDULE LAB	90,792.00	7,004.00
EKG/ECG	13,652.00	5,498.00	MRI SERVICES	0.00	7,909.00
IV THERAPY	263,344.00	22,301.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,296,450.01	102,544.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,325.00	1,275.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	296,196.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,766.00	3,374.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	237,436.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,344,985.56	104,429.04
RADIOLOGY THERAPEUTIC	152,748.00	1,842.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	86.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,561.00	1,686.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,746,887.36	0.00
LITHOTRIPSY	242,244.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,852.00	630.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,390.00	3,956.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,425.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	519,590.00	201,830.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	905.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,699.00	2,654.00			
			TOTAL ANCILLARY	12,012,458.35	497,322.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,012,458.35	497,322.04

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: 08/28/2018
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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	08/01/16	THROUGH	07/31/17
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: 08/28/2018
 Run Time: 23:44:14
 Page: 1

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,067,453.86	ADJUSTMENTS	3,482,804.30
COVERED CHARGES	80,660,483.32	CONTRACTUAL ALLOW	62,612,074.85
NON-COVERD CHARGES	2,406,970.54	TOTAL MEDICAID LIAB	18,048,408.47
		LESS: COB	247,584.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,800,824.43

TOTAL NUMBER OF ADMISSIONS 975

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,416		0	6,470,031.00		1,029,797.00
ROUTINE NURSERY	327		0	591,601.00		85,063.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		4,126.40
TOTAL ROUTINE	5,743		0	7,061,632.00		1,118,986.40
SPECIAL CARE SERVICES						
CCU	442		0	1,588,894.00		0.00
ICU	904		0	3,432,422.00		0.00
NICU	88		0	314,600.00		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	1,434		0	5,335,916.00		0.00
TOTAL ACCOMODATIONS	7,177		0	12,397,548.00		1,118,986.40

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,982,273.48	110,406.42	OTHER LAB	536,269.00	0.00
MED/SURG SUPPLY	4,149,042.50	552,075.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,827,939.00	114,666.00	EDUCATION & TRAINING	3,956.00	0.00
RADIOLOGY-DIAGNOSTIC	1,784,165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,069,350.00	22,488.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	622,624.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	595,752.00	0.00	MRI SERVICES	633,747.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,528,659.00	10,422.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,717.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,662,506.00	15,124.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,078,337.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	936,708.00	9,052.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,182,155.00	894.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	567,067.00	1,531.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	482,454.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	301,102.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	244,724.44	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	260,037.76	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,765,000.00	49,028.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,460.00	44,052.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,626,056.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	66,822.00
OTHER IMAGING SERVICE	548,847.00	9,065.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,704,502.00	255,567.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	218,512.00	26,791.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,771,949.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	65,641.00	0.00			
ORGAN ACQUISITION	1,643,931.00	0.00			
TREATMENT/OBSERV. RM	393,451.20	0.00			
			TOTAL ANCILLARY	68,262,935.32	1,287,984.14
			TOTAL ACCOMODATIONS	12,397,548.00	1,118,986.40
			TOTAL CHARGES	80,660,483.32	2,406,970.54

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216284002040	09/20/16 - 09/28/16	10/17/16	0.00	4,196.00	0.00	0.00	0.00
614	2216291000465	09/13/16 - 09/17/16	10/24/16	0.00	4,569.00	0.00	0.00	0.00
614	2016292042541	09/23/16 - 10/14/16	10/24/16	0.00	5,021.00	0.00	0.00	0.00
614	2016344032049	08/01/16 - 08/10/16	12/12/16	0.00	4,196.00	0.00	0.00	0.00
614	2016355063376	12/11/16 - 12/15/16	12/26/16	0.00	4,196.00	0.00	0.00	0.00
614	2217039000582	02/02/17 - 02/04/17	02/13/17	0.00	4,569.00	0.00	0.00	0.00
614	2017052070013	02/12/17 - 02/16/17	02/27/17	0.00	4,196.00	0.00	0.00	0.00
614	2017088056051	03/18/17 - 03/25/17	04/03/17	0.00	4,196.00	0.00	0.00	0.00
-1	2217131000928	04/24/17 - 05/01/17	06/05/17	0.00	446.00	0.00	0.00	0.00
614	2017158022855	12/01/16 - 12/13/16	06/12/17	0.00	4,196.00	0.00	0.00	0.00
614	2217194011052	06/22/17 - 07/05/17	07/17/17	0.00	4,569.00	0.00	0.00	0.00
614	2017342040327	06/06/17 - 06/16/17	12/11/17	0.00	4,569.00	0.00	0.00	0.00
614	2017359003667	06/05/17 - 06/12/17	01/01/18	0.00	4,569.00	0.00	0.00	0.00
614	2018040056166	03/23/17 - 03/27/17	02/12/18	0.00	4,196.00	0.00	0.00	0.00
614	2018122059320	04/10/17 - 04/19/17	05/07/18	0.00	4,569.00	0.00	0.00	0.00
614	2018225011300	01/16/17 - 01/20/17	08/20/18	0.00	4,569.00	0.00	0.00	0.00
TOTAL				0.00	66,822.00	0.00	0.00	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL
 1968 PEACHTREE RD NW
 ATLANTA,GA 30309-1281

PROVIDER NUMBER 000001504A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,430,068.17	ADJUSTMENTS	0.00
COVERED CHARGES	2,951,194.91	CONTRACTUAL ALLOW	1,448,834.49
NON-COVERD CHARGES	478,873.26	TOTAL MEDICAID LIAB	1,502,360.42
		LESS: COB	1,502,360.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 37

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	124		0	148,180.00		22,040.00
ROUTINE NURSERY	202		57	402,528.00		201,132.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	326		57	550,708.00		223,172.00
SPECIAL CARE SERVICES						
CCU	4		0	14,276.00		0.00
ICU	56		0	201,020.00		0.00
NICU	50		27	178,750.00		96,525.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	110		27	394,046.00		96,525.00
TOTAL ACCOMODATIONS	436		84	944,754.00		319,697.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	334,215.03	39,994.26	OTHER LAB	31,211.00	484.00
MED/SURG SUPPLY	97,563.10	10,777.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	328,617.00	48,650.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,498.00	26,658.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,440.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,079.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,048.00	0.00	MRI SERVICES	16,693.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	109,613.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	98,591.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	352,298.00	29,430.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,076.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	27,612.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,583.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,089.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,233.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,320.06	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	31,518.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,776.00	462.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	109,306.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,747.00	1,660.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,626.00	924.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,292.00	137.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	92,648.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,543.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,885.00	0.00			
			TOTAL ANCILLARY	2,006,440.91	159,176.26
			TOTAL ACCOMODATIONS	944,754.00	319,697.00
			TOTAL CHARGES	2,951,194.91	478,873.26

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

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

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PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,890,434.11	ADJUSTMENTS	451,526.42
COVERED CHARGES	16,451,727.49	CONTRACTUAL ALLOW	14,186,050.79
NON-COVERD CHARGES	5,438,706.62	TOTAL MEDICAID LIAB	2,265,676.70
		LESS: COB	60,669.04
		LESS: COPAYMENT	5,946.91
		REIMBURSEMENT	2,199,060.75
		ALL OTHER	1,892,488.56
		FEE SCHEDULE-LAB	189,248.45
		INJECTABLE DRUGS	117,323.74
		TOTAL NUMBER OF CLAIMS	3,941

PIEDMONT HOSPITAL
 1968 PEACHTREE RD NW
 ATLANTA,GA 30309-1281

PROVIDER NUMBER
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PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	296,926.47	83.21	OTHER LAB	258,229.00	2,780.00
MED/SURG SUPPLY	327,349.47	520,655.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	344.00
RADIOLOGY-DIAGNOSTIC	660,315.00	133,689.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,849,180.00	572,265.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,728.00	10,233.04	FEE SCHEDULE LAB	2,800,806.00	242,458.00
EKG/ECG	277,437.00	15,593.00	MRI SERVICES	523,673.00	119,598.00
IV THERAPY	40,004.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,472,687.00	495,010.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,224.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	123,877.00	21,428.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	155,121.00	1,490.00	AMBULANCE	0.00	0.00
GI SERVICES	246,686.00	129,019.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,059,959.00	97,826.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	231,090.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	871,229.07	922,486.53
RADIOLOGY THERAPEUTIC	272,405.00	435,046.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	546.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,958.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	70,040.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	351,035.00	43,095.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	146,370.32	582,623.54
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	19,626.00
OTHER IMAGING SERVICE	452,118.00	123,197.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	144,654.00	7,675.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	283,414.00	146,718.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	921,917.00	720,164.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	294,118.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	377,175.16	2,060.00			
			TOTAL ANCILLARY	16,451,727.49	5,438,706.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,451,727.49	5,438,706.62

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

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

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PIEDMONT HOSPITAL
 1968 PEACHTREE RD NW
 ATLANTA,GA 30309-1281

PROVIDER NUMBER
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916204000586	07/13/16 - 07/13/16	07/25/16	0.00	5,021.00	0.00	0.00	0.00
614	2016315051238	11/04/16 - 11/04/16	11/14/16	0.00	373.00	0.00	0.00	0.00
948	2017037011769	02/01/17 - 02/01/17	02/13/17	0.00	446.00	0.00	0.00	0.00
614	2017103054140	04/10/17 - 04/10/17	04/17/17	0.00	4,196.00	0.00	0.00	0.00
614	2017103054140	04/10/17 - 04/10/17	04/17/17	0.00	373.00	0.00	0.00	0.00
614	5917164000806	04/03/17 - 04/03/17	06/19/17	0.00	4,196.00	0.00	0.00	0.00
614	5917165001668	06/02/17 - 06/02/17	06/19/17	0.00	5,021.00	0.00	0.00	0.00
TOTAL				0.00	19,626.00	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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	685,981.45	ADJUSTMENTS	0.00
COVERED CHARGES	361,239.70	CONTRACTUAL ALLOW	139,069.04
NON-COVERD CHARGES	324,741.75	TOTAL MEDICAID LIAB	222,170.66
		LESS: COB	222,031.09
		LESS: COPAYMENT	139.57
		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,592.82	0.00	OTHER LAB	11,496.00	0.00
MED/SURG SUPPLY	21,636.46	9,420.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,205.00	17,160.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,081.00	25,132.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	58,745.00	4,428.00
EKG/ECG	5,030.00	503.00	MRI SERVICES	31,180.00	9,062.00
IV THERAPY	3,587.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,326.00	36,120.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,892.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	297.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,679.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,539.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,727.00	374.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,018.75	58,396.75
RADIOLOGY THERAPEUTIC	2,501.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,567.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,689.07	85,014.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,569.00
OTHER IMAGING SERVICE	10,164.00	8,233.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,884.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,620.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,197.00	59,413.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,703.60	0.00			
			TOTAL ANCILLARY	361,239.70	324,741.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	361,239.70	324,741.75

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

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5917235001330	06/13/17 - 06/13/17	08/28/17	0.00	4,196.00	0.00	0.00	0.00
614	5917235001330	06/13/17 - 06/13/17	08/28/17	0.00	373.00	0.00	0.00	0.00
TOTAL				0.00	4,569.00	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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PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	287,127.85	ADJUSTMENTS	273.70
COVERED CHARGES	255,420.76	CONTRACTUAL ALLOW	248,375.66
NON-COVERD CHARGES	31,707.09	TOTAL MEDICAID LIAB	7,045.10
		LESS: COB	1,005.00
		LESS: COPAYMENT	239.30
		REIMBURSEMENT	5,800.80
		TOTAL NUMBER OF CLAIMS	108

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,163.17	0.00	OTHER LAB	3,174.00	1,316.00
MED/SURG SUPPLY	678.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,152.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,500.00	13,773.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,000.00	1,915.00
EKG/ECG	2,012.00	0.00	MRI SERVICES	5,746.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	264.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	143,998.00	3,079.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,186.59	944.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,547.00	10,680.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	255,420.76	31,707.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	255,420.76	31,707.09

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

Run Date: 08/28/2018
Run Time: 23:45:15
Page: 14

PIEDMONT HOSPITAL
1968 PEACHTREE RD NW
ATLANTA,GA 30309-1281

PROVIDER NUMBER
000001504A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/28/2018
Run Time: 23:45:16
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,448,434.75	ADJUSTMENTS	54,968.24
COVERED CHARGES	1,861,906.98	CONTRACTUAL ALLOW	1,655,945.68
NON-COVERD CHARGES	586,527.77	TOTAL MEDICAID LIAB	205,961.30
		LESS: COB	0.00
		LESS: COPAYMENT	159.00
		REIMBURSEMENT	205,802.30
		TOTAL NUMBER OF CLAIMS	37

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,235.18	0.00	OTHER LAB	2,701.00	0.00
MED/SURG SUPPLY	79,786.22	98,338.82	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,149.00	74,501.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,223.00	3,542.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	738.00	FEE SCHEDULE LAB	31,621.00	1,467.00
EKG/ECG	2,515.00	3,521.00	MRI SERVICES	6,236.00	0.00
IV THERAPY	2,283.00	1,086.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	420,877.00	41,661.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,452.00	297.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,231.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,492.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	621,523.93	190,675.71
RADIOLOGY THERAPEUTIC	32,026.00	1,032.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,293.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,502.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	316,835.09	95,957.24
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,293.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	227,258.00	68,916.00			
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	14,169.56	0.00			
			TOTAL ANCILLARY	1,861,906.98	586,527.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,861,906.98	586,527.77

Report : 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: 08/28/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/28/2018
 Run Time: 23:55:11
 Page: 1

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,620,503.02	ADJUSTMENTS	544,279.79
COVERED CHARGES	42,071,551.02	CONTRACTUAL ALLOW	36,516,891.76
NON-COVERD CHARGES	548,952.00	TOTAL MEDICAID LIAB	5,554,659.26
		LESS: COB	45,440.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,509,218.76

TOTAL NUMBER OF ADMISSIONS 669

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,159		0	3,646,284.00		247,495.00
ROUTINE NURSERY	142		0	242,810.00		18,780.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,301		0	3,889,094.00		266,275.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	635		0	2,617,258.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	635		0	2,617,258.00		0.00
TOTAL ACCOMODATIONS	2,936		0	6,506,352.00		266,275.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,677,979.17	0.00	OTHER LAB	170,361.00	0.00
MED/SURG SUPPLY	1,246,147.00	3,600.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,855,123.00	2,260.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	780,429.00	0.00	OTHER THERAPEUTIC SVC	0.00	5,328.00
CT SCAN	2,937,318.00	28,344.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	488,711.58	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	503,603.00	0.00	MRI SERVICES	582,451.00	0.00
IV THERAPY	98,314.21	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,042,928.00	120,951.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	540,179.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,377,033.00	123.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	792,380.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	127,426.75	4,807.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,452,981.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	266,621.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	184,382.00	0.00	INJECTABLE DRUGS	5,826,481.13	5,162.00
RADIOLOGY THERAPEUTIC	64,211.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	374,183.91	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	81,862.27	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	58,860.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,054.00	1,160.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	302,529.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	127,363.50	27,852.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	164,480.00	69,829.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	427,027.00	0.00			
AUDIOLOGY	0.00	13,261.00			
CARDIOLOGY	1,932,227.15	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,196.85	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,355.00	0.00			
			TOTAL ANCILLARY	35,565,199.02	282,677.00
			TOTAL ACCOMODATIONS	6,506,352.00	266,275.00
			TOTAL CHARGES	42,071,551.02	548,952.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	232,433.28	ADJUSTMENTS	0.00
COVERED CHARGES	229,454.28	CONTRACTUAL ALLOW	175,566.73
NON-COVERD CHARGES	2,979.00	TOTAL MEDICAID LIAB	53,887.55
		LESS: COB	53,887.55
		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	15		0	25,050.00		2,025.00
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	15		0	25,050.00		2,025.00
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	15		0	25,050.00		2,025.00

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 10/01/16 THROUGH 09/30/17
 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	5,341.00	0.00	OTHER LAB	2,901.00	0.00
MED/SURG SUPPLY	12,013.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,748.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,724.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,534.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,123.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,704.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	320.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,254.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,718.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,420.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,150.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,297.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,976.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,253.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,623.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,584.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,238.00	954.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,376.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,106.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	204,404.28	954.00
			TOTAL ACCOMODATIONS	25,050.00	2,025.00
			TOTAL CHARGES	229,454.28	2,979.00

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: 08/28/2018
Run Time: 23:55:21
Page: 5

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

PROVIDER NUMBER
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,697,803.49	ADJUSTMENTS	75,109.65
COVERED CHARGES	27,616,568.91	CONTRACTUAL ALLOW	25,847,177.65
NON-COVERD CHARGES	3,081,234.58	TOTAL MEDICAID LIAB	1,769,391.26
		LESS: COB	1,668.11
		LESS: COPAYMENT	3,495.25
		REIMBURSEMENT	1,764,227.90
		ALL OTHER	1,562,538.47
		FEE SCHEDULE-LAB	187,295.17
		INJECTABLE DRUGS	14,394.26

TOTAL NUMBER OF CLAIMS 4,549

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

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

Run Date: 08/28/2018
 Run Time: 23:55:21
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	610,676.74	96,193.15	OTHER LAB	207,876.00	2,200.00
MED/SURG SUPPLY	625,726.75	9,810.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,009,172.00	221,776.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,845,036.00	413,995.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	10,200.00	FEE SCHEDULE LAB	6,742,014.00	201,413.50
EKG/ECG	644,215.00	6,816.00	MRI SERVICES	339,104.00	80,960.00
IV THERAPY	813,585.60	25,607.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,672,539.03	411,907.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	71,014.00	1,668.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	102,058.00	72,285.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,248,564.00	2,982.50	AMBULANCE	0.00	0.00
GI SERVICES	236,166.70	60,094.55	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,883,617.30	47,277.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	520,139.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	198,845.70	145,953.20
RADIOLOGY THERAPEUTIC	550,587.00	790,692.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	10,246.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	873.00	6,168.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,924.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	44,429.25	8,266.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	135,296.00	0.00
LITHOTRIPSY	71,857.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	526,393.75	83,435.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,608.00	16,218.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	472,488.00	114,842.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	728,124.00	233,398.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,583.11	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	273,979.48	2,906.00			
			TOTAL ANCILLARY	27,616,568.91	3,081,234.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,616,568.91	3,081,234.58

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

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

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	541,579.07	ADJUSTMENTS	0.00
COVERED CHARGES	426,854.57	CONTRACTUAL ALLOW	343,005.88
NON-COVERD CHARGES	114,724.50	TOTAL MEDICAID LIAB	83,848.69
		LESS: COB	83,785.69
		LESS: COPAYMENT	63.00
		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

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/16 THROUGH 09/30/17
 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	14,996.40	617.00	OTHER LAB	1,100.00	0.00
MED/SURG SUPPLY	11,922.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,469.00	4,805.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,842.00	41,048.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	94,099.00	2,998.00
EKG/ECG	7,203.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,772.17	1,054.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,352.00	57,933.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,006.00	818.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,152.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,599.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,373.00	1,459.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,906.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,583.00	20.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	408.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,712.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,992.00	1,839.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,862.00	954.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,753.00	150.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,029.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,775.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,978.00	0.00			
			TOTAL ANCILLARY	426,854.57	114,724.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	426,854.57	114,724.50

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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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,419,020.45	ADJUSTMENTS	332.64
COVERED CHARGES	2,311,213.58	CONTRACTUAL ALLOW	2,276,083.26
NON-COVERD CHARGES	107,806.87	TOTAL MEDICAID LIAB	35,130.32
		LESS: COB	0.00
		LESS: COPAYMENT	1,332.00
		REIMBURSEMENT	33,798.32
		TOTAL NUMBER OF CLAIMS	628

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 10/01/16 THROUGH 09/30/17
 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	23,561.50	10,712.75	OTHER LAB	5,500.00	0.00
MED/SURG SUPPLY	6,580.00	91.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	144,636.00	15,289.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	378,545.00	30,498.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	710,501.00	15,323.00
EKG/ECG	52,824.00	0.00	MRI SERVICES	12,018.00	0.00
IV THERAPY	56,282.58	2,577.62	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,747.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	856,969.00	2,078.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,944.50	8,707.50
RADIOLOGY THERAPEUTIC	11,736.00	21,576.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,438.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	931.00	954.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,311,213.58	107,806.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,311,213.58	107,806.87

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,069.28	ADJUSTMENTS	0.00
COVERED CHARGES	34,805.28	CONTRACTUAL ALLOW	23,333.93
NON-COVERD CHARGES	7,264.00	TOTAL MEDICAID LIAB	11,471.35
		LESS: COB	11,459.35
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	951.00	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	1,719.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,513.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,664.00	1,751.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	320.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	288.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,728.00	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	134.50	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	34,805.28	7,264.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,805.28	7,264.00

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	478,248.14	ADJUSTMENTS	0.00
COVERED CHARGES	414,937.14	CONTRACTUAL ALLOW	387,734.14
NON-COVERD CHARGES	63,311.00	TOTAL MEDICAID LIAB	27,203.00
		LESS: COB	0.00
		LESS: COPAYMENT	16.17
		REIMBURSEMENT	27,186.83

TOTAL NUMBER OF CLAIMS 5

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 10/01/16 THROUGH 09/30/17
 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	8,697.00	317.00	OTHER LAB	1,801.00	0.00
MED/SURG SUPPLY	38,854.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,714.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,534.00	6,338.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,161.00	57.00
EKG/ECG	2,556.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,637.64	510.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	104,021.00	35,510.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,949.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,188.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,868.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,551.25	708.00
RADIOLOGY THERAPEUTIC	12,064.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,903.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,368.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,144.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	101,421.00	19,871.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,504.00	0.00			
			TOTAL ANCILLARY	414,937.14	63,311.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	414,937.14	63,311.00

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: 08/28/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/28/2018
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,554,040.87	ADJUSTMENTS	1,442,002.42
COVERED CHARGES	26,254,274.09	CONTRACTUAL ALLOW	16,936,104.38
NON-COVERD CHARGES	1,299,766.78	TOTAL MEDICAID LIAB	9,318,169.71
		LESS: COB	211,080.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,107,088.95

TOTAL NUMBER OF ADMISSIONS 555

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,476		0	3,384,984.00		239,319.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,476		0	3,384,984.00		239,319.00
SPECIAL CARE SERVICES						
CCU	158		0	908,801.00		17,550.00
ICU	703		0	3,361,071.00		49,728.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	861		0	4,269,872.00		67,278.00
TOTAL ACCOMODATIONS	3,337		0	7,654,856.00		306,597.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA
 5665 PEACHTREE DUNWOODY RD NE
 ATLANTA,GA 30342-1701

PROVIDER NUMBER
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	883,604.60	56,077.60	OTHER LAB	151,229.00	5,346.00
MED/SURG SUPPLY	1,068,134.00	58,709.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,490,452.00	122,078.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	493,918.00	13,241.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	945,848.00	10,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	191,757.03	3,495.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	94,885.00	2,044.00	MRI SERVICES	342,803.00	4,265.00
IV THERAPY	160.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,105,287.00	61,455.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	785,832.00	18,623.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	560,720.00	10,967.00	AMBULANCE	0.00	0.00
GI SERVICES	196,023.00	8,655.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	713,202.00	3,412.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	173,688.00	3,885.00	DRUG-SPECIFIC/HOME IV	0.00	174,825.03
LABORATORY PATHOLOGIC	152,532.00	6,691.00	INJECTABLE DRUGS	1,972,244.38	90,289.00
RADIOLOGY THERAPEUTIC	70,080.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	127,193.36	2,129.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	91,177.28	6,322.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	266,067.00	41,736.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	248.00	1,862.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,207,248.44	11,924.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	168,028.00
OTHER IMAGING SERVICE	74,987.00	99.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	274,736.00	26,225.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	138,600.00	16,111.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	983,955.00	63,221.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,459.00	705.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,348.00	0.00			
			TOTAL ANCILLARY	18,599,418.09	993,169.78
			TOTAL ACCOMODATIONS	7,654,856.00	306,597.00
			TOTAL CHARGES	26,254,274.09	1,299,766.78

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216295016342	09/02/16 - 09/02/16	10/24/16	0.00	8,530.00	0.00	0.00	0.00
615	2017026085868	01/13/17 - 01/20/17	01/30/17	0.00	8,530.00	0.00	0.00	0.00
614	2217031004159	11/17/16 - 12/09/16	02/06/17	0.00	2,569.00	0.00	0.00	0.00
615	2317037000104	12/23/16 - 12/27/16	02/27/17	0.00	8,530.00	0.00	1,289.46	0.00
614	5217069000276	10/29/16 - 12/07/16	03/20/17	0.00	4,265.00	0.00	0.00	0.00
614	2317081000038	11/24/16 - 11/30/16	04/24/17	0.00	2,569.00	0.00	2,286.87	0.00
615	2317114000147	11/30/16 - 12/04/16	05/29/17	0.00	6,834.00	0.00	2,603.48	0.00
614	2317122000107	11/21/16 - 11/24/16	06/05/17	0.00	4,265.00	0.00	2,248.43	0.00
615	2017158064093	05/30/17 - 05/31/17	06/12/17	0.00	2,569.00	0.00	0.00	0.00
614	2317163000027	04/19/17 - 04/25/17	07/24/17	0.00	4,265.00	0.00	2,069.18	0.00
614	2017173064638	05/02/17 - 05/09/17	06/26/17	0.00	2,366.00	0.00	0.00	0.00
614	2317192000228	02/21/17 - 03/11/17	07/31/17	0.00	2,569.00	0.00	5,130.77	0.00
615	2317192000228	02/21/17 - 03/11/17	07/31/17	0.00	6,834.00	0.00	5,130.77	0.00
615	2317192000234	03/08/17 - 03/16/17	07/31/17	0.00	6,834.00	0.00	3,414.99	0.00
615	2317205000095	03/21/17 - 03/25/17	08/28/17	0.00	8,530.00	0.00	1,674.84	0.00
615	2317220000022	06/18/17 - 06/20/17	09/25/17	0.00	6,834.00	0.00	3,256.34	0.00
615	2317223000100	04/17/17 - 04/19/17	09/25/17	0.00	8,530.00	0.00	1,482.11	0.00
615	2317226000152	06/16/17 - 06/17/17	09/25/17	0.00	8,530.00	0.00	1,337.34	0.00
615	2317228000120	04/24/17 - 05/11/17	09/25/17	0.00	5,138.00	0.00	8,168.22	0.00
615	2317230000144	06/15/17 - 06/17/17	09/25/17	0.00	5,138.00	0.00	888.81	0.00
615	2317255000096	06/21/17 - 06/21/17	10/09/17	0.00	5,138.00	0.00	1,591.13	0.00
615	5217261000123	07/09/17 - 07/20/17	09/25/17	0.00	6,834.00	0.00	0.00	0.00
615	5217276000221	05/18/17 - 06/12/17	10/09/17	0.00	6,834.00	0.00	0.00	0.00
614	2017311085991	06/01/17 - 06/16/17	11/13/17	0.00	2,569.00	0.00	0.00	0.00
615	2317340000022	02/22/17 - 02/24/17	12/18/17	0.00	8,530.00	0.00	1,354.76	0.00
615	2317346000190	07/21/17 - 08/04/17	01/15/18	0.00	15,364.00	0.00	0.00	0.00
615	2318136000092	08/25/17 - 08/27/17	06/04/18	0.00	8,530.00	0.00	1,338.42	0.00
TOTAL				0.00	168,028.00	0.00	45,265.92	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: 08/28/2018
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	338,173.83	ADJUSTMENTS	0.00
COVERED CHARGES	338,065.83	CONTRACTUAL ALLOW	171,217.15
NON-COVERD CHARGES	108.00	TOTAL MEDICAID LIAB	166,848.68
		LESS: COB	166,848.68
		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	9		0	13,041.00		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	9		0	13,041.00		108.00
SPECIAL CARE SERVICES						
CCU	2		0	11,700.00		0.00
ICU	3		0	14,626.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	26,326.00		0.00
TOTAL ACCOMODATIONS	14		0	39,367.00		108.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,908.19	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,765.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,490.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,018.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,464.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,112.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,314.00	0.00	MRI SERVICES	8,530.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,907.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,161.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,472.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,974.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,562.14	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	655.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	81,675.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,000.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	59,791.00	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	0.00	0.00			
			TOTAL ANCILLARY	298,698.83	0.00
			TOTAL ACCOMODATIONS	39,367.00	108.00
			TOTAL CHARGES	338,065.83	108.00

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,577,309.48	ADJUSTMENTS	73,691.81
COVERED CHARGES	4,818,063.17	CONTRACTUAL ALLOW	3,980,638.86
NON-COVERD CHARGES	1,759,246.31	TOTAL MEDICAID LIAB	837,424.31
		LESS: COB	4,090.14
		LESS: COPAYMENT	2,081.38
		REIMBURSEMENT	831,252.79
		ALL OTHER	738,479.68
		FEE SCHEDULE-LAB	70,259.40
		INJECTABLE DRUGS	22,513.71

TOTAL NUMBER OF CLAIMS 1,605

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,710.87	39,288.82	OTHER LAB	75,830.00	891.00
MED/SURG SUPPLY	147,697.00	776.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	180,122.00	45,670.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	434,663.00	255,343.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,124.02	FEE SCHEDULE LAB	626,270.00	25,774.00
EKG/ECG	55,728.74	1,825.00	MRI SERVICES	183,445.00	209,697.00
IV THERAPY	2,716.00	244.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	617,577.00	229,753.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,863.00	5,725.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	137,526.00	2,424.00	AMBULANCE	0.00	0.00
GI SERVICES	88,373.00	49,807.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	939,215.00	17,862.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	103,432.00	1,728.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	228,832.72	66,955.33
RADIOLOGY THERAPEUTIC	71,705.00	109,355.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,026.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,948.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	21,541.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,148.00	1,051.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,309.84	149,751.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	54,622.00
OTHER IMAGING SERVICE	186,540.00	85,944.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,432.00	1,708.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,446.00	125,306.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	356,063.00	244,185.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	196,418.00	2,922.00			
			TOTAL ANCILLARY	4,818,063.17	1,759,246.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,818,063.17	1,759,246.31

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016306072767	10/20/16 - 10/20/16	11/07/16	0.00	2,569.00	0.00	0.00	0.00
615	2016306072767	10/20/16 - 10/20/16	11/07/16	0.00	2,569.00	0.00	0.00	0.00
615	2016350098349	12/06/16 - 12/06/16	12/19/16	0.00	4,265.00	0.00	0.00	0.00
615	2016350098349	12/06/16 - 12/06/16	12/19/16	0.00	4,265.00	0.00	0.00	0.00
615	2017058037563	02/17/17 - 02/17/17	03/06/17	0.00	4,265.00	0.00	0.00	0.00
615	2017058037563	02/17/17 - 02/17/17	03/06/17	0.00	4,265.00	0.00	0.00	0.00
615	5917115000760	03/02/17 - 03/02/17	05/01/17	0.00	2,569.00	0.00	0.00	0.00
615	5917115000760	03/02/17 - 03/02/17	05/01/17	0.00	4,265.00	0.00	0.00	0.00
615	2017117004903	04/17/17 - 04/17/17	05/01/17	0.00	4,265.00	0.00	0.00	0.00
615	2017117004903	04/17/17 - 04/17/17	05/01/17	0.00	4,265.00	0.00	0.00	0.00
615	2017157074517	04/26/17 - 04/26/17	06/12/17	0.00	4,265.00	0.00	0.00	0.00
615	2017157074517	04/26/17 - 04/26/17	06/12/17	0.00	4,265.00	0.00	0.00	0.00
615	2017214074853	07/25/17 - 07/25/17	08/07/17	0.00	4,265.00	0.00	0.00	0.00
615	2017214074853	07/25/17 - 07/25/17	08/07/17	0.00	4,265.00	0.00	0.00	0.00
TOTAL				0.00	54,622.00	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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	298,060.62	ADJUSTMENTS	0.00
COVERED CHARGES	139,910.53	CONTRACTUAL ALLOW	35,234.98
NON-COVERD CHARGES	158,150.09	TOTAL MEDICAID LIAB	104,675.55
		LESS: COB	104,610.30
		LESS: COPAYMENT	65.25
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 56

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,090.56	3,310.53	OTHER LAB	2,336.00	0.00
MED/SURG SUPPLY	7,221.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,767.00	7,569.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,329.00	18,697.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,084.00	FEE SCHEDULE LAB	15,387.00	441.00
EKG/ECG	876.00	146.00	MRI SERVICES	4,265.00	25,590.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,702.00	43,290.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	996.00
RESPIRATORY SERVICES	381.00	555.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,905.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,961.00	1,134.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,308.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,923.63	3,775.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	464.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,982.34	35,048.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,057.00	8,391.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,908.00	1,069.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,806.00	3,668.00			
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	0.00	2,922.00			
			TOTAL ANCILLARY	139,910.53	158,150.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	139,910.53	158,150.09

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,643.34	ADJUSTMENTS	105.88
COVERED CHARGES	54,696.30	CONTRACTUAL ALLOW	52,123.06
NON-COVERD CHARGES	18,947.04	TOTAL MEDICAID LIAB	2,573.24
		LESS: COB	0.00
		LESS: COPAYMENT	120.16
		REIMBURSEMENT	2,453.08
		TOTAL NUMBER OF CLAIMS	46

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

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11.15	680.00	OTHER LAB	0.00	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	903.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,612.00	134.00
EKG/ECG	584.00	0.00	MRI SERVICES	0.00	4,265.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,823.00	222.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,485.15	269.04
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	8,530.00
OTHER IMAGING SERVICE	369.00	383.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,625.00	0.00			
			TOTAL ANCILLARY	54,696.30	18,947.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,696.30	18,947.04

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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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017144081330	05/17/17 - 05/17/17	05/29/17	0.00	4,265.00	0.00	0.00	0.00
615	2017144081330	05/17/17 - 05/17/17	05/29/17	0.00	4,265.00	0.00	0.00	0.00
TOTAL				0.00	8,530.00	0.00	0.00	0.00

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,206.62	ADJUSTMENTS	0.00
COVERED CHARGES	15,779.31	CONTRACTUAL ALLOW	9,675.05
NON-COVERD CHARGES	29,427.31	TOTAL MEDICAID LIAB	6,104.26
		LESS: COB	6,087.69
		LESS: COPAYMENT	16.57
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	600.00	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	618.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,211.00	14,374.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,801.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	4,265.00	12,795.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,556.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,231.31	197.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,461.00			
			TOTAL ANCILLARY	15,779.31	29,427.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,779.31	29,427.31

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	291,700.65	ADJUSTMENTS	11,669.46
COVERED CHARGES	277,532.44	CONTRACTUAL ALLOW	236,657.83
NON-COVERD CHARGES	14,168.21	TOTAL MEDICAID LIAB	40,874.61
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	40,838.61

TOTAL NUMBER OF CLAIMS 7

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,252.36	213.08	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,175.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,525.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,504.00	147.00
EKG/ECG	292.00	438.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	115,982.00	609.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,939.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,192.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,505.08	1,687.13
RADIOLOGY THERAPEUTIC	491.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,208.00	4,646.00
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	600.00	2,238.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,768.00	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	0.00	0.00			
			TOTAL ANCILLARY	277,532.44	14,168.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	277,532.44	14,168.21

Report : 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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,082.33	ADJUSTMENTS	0.00
COVERED CHARGES	31,992.97	CONTRACTUAL ALLOW	15,073.23
NON-COVERD CHARGES	6,089.36	TOTAL MEDICAID LIAB	16,919.74
		LESS: COB	16,916.74
		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

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,247.62	8.36	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,342.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	278.00	0.00
EKG/ECG	0.00	146.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	16.35	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	3,840.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,109.00	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	0.00	0.00			
			TOTAL ANCILLARY	31,992.97	6,089.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,992.97	6,089.36

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,558,759.22	ADJUSTMENTS	225,593.32
COVERED CHARGES	13,633,187.22	CONTRACTUAL ALLOW	9,325,824.37
NON-COVERD CHARGES	925,572.00	TOTAL MEDICAID LIAB	4,307,362.85
		LESS: COB	57,851.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,249,511.20

TOTAL NUMBER OF ADMISSIONS 481

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,303		0	1,435,906.00		73,441.50
ROUTINE NURSERY	273		0	299,832.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,576		0	1,735,738.00		73,441.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	758		0	1,636,748.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		125	0.00		143,232.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	758		125	1,636,748.00		143,232.00
TOTAL ACCOMODATIONS	2,334		125	3,372,486.00		216,673.50

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,446,493.55	0.00	OTHER LAB	97,998.00	0.00
MED/SURG SUPPLY	429,382.15	2,881.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	814,210.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	256,518.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	551,373.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	153,499.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	106,381.00	0.00	MRI SERVICES	213,892.00	0.00
IV THERAPY	251,394.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,330,586.00	9,939.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	176,840.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	805,801.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	412,584.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	74,637.00	2,210.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	606,430.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	271,332.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	59,533.00	0.00	INJECTABLE DRUGS	4,508.93	508.50
RADIOLOGY THERAPEUTIC	3,615.59	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	133,213.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,663.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	157,590.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	796.00	3,231.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	589,364.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	126,440.00
OTHER IMAGING SERVICE	113,186.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	78,614.00	3,864.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	40,477.00	8,452.00			
AUDIOLOGY	5,760.00	0.00			
CARDIOLOGY	551,471.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,927.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,005.00	0.00			
			TOTAL ANCILLARY	10,260,701.22	708,898.50
			TOTAL ACCOMODATIONS	3,372,486.00	216,673.50
			TOTAL CHARGES	13,633,187.22	925,572.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016219005837	07/03/16 - 07/18/16	08/15/16	0.00	2,221.00	0.00	0.00	0.00
614	2016245000142	08/07/16 - 08/16/16	09/05/16	0.00	3,840.00	0.00	0.00	0.00
615	2016245000142	08/07/16 - 08/16/16	09/05/16	0.00	2,221.00	0.00	0.00	0.00
614	2216246004706	08/08/16 - 08/22/16	09/05/16	0.00	2,458.00	0.00	0.00	0.00
615	2216246004706	08/08/16 - 08/22/16	09/05/16	0.00	2,221.00	0.00	0.00	0.00
615	2016253085234	08/02/16 - 08/04/16	09/19/16	0.00	2,221.00	0.00	0.00	0.00
614	2016286052169	09/17/16 - 09/23/16	10/17/16	0.00	2,669.00	0.00	0.00	0.00
615	2016286052186	09/17/16 - 09/19/16	10/17/16	0.00	6,651.00	0.00	0.00	0.00
618	2216294000594	07/17/16 - 07/21/16	10/24/16	0.00	2,677.00	0.00	0.00	0.00
614	2316350000101	09/19/16 - 09/21/16	01/09/17	0.00	3,665.00	0.00	783.66	0.00
614	2016357007678	12/05/16 - 12/10/16	12/26/16	0.00	3,665.00	0.00	0.00	0.00
615	2016364076261	11/18/16 - 11/22/16	01/02/17	0.00	2,221.00	0.00	0.00	0.00
614	2017012072656	12/20/16 - 12/30/16	01/16/17	0.00	5,015.00	0.00	0.00	0.00
615	2017020074358	07/16/16 - 08/12/16	01/30/17	0.00	3,422.00	0.00	0.00	0.00
614	2017027079899	01/06/17 - 01/08/17	02/06/17	0.00	3,665.00	0.00	0.00	0.00
615	2017032090983	01/03/17 - 01/24/17	02/06/17	0.00	4,442.00	0.00	0.00	0.00
615	2217040016958	01/12/17 - 01/16/17	02/13/17	0.00	2,221.00	0.00	0.00	0.00
614	2017040115029	12/16/16 - 12/21/16	02/13/17	0.00	3,760.00	0.00	0.00	0.00
615	2017040115029	12/16/16 - 12/21/16	02/13/17	0.00	2,221.00	0.00	0.00	0.00
615	2217046000951	10/01/16 - 10/14/16	02/20/17	0.00	2,221.00	0.00	0.00	0.00
614	2017047112851	02/01/17 - 02/04/17	02/20/17	0.00	2,669.00	0.00	0.00	0.00
614	2017059069600	02/12/17 - 02/15/17	03/06/17	0.00	2,669.00	0.00	0.00	0.00
614	2017067072332	11/04/16 - 11/17/16	03/13/17	0.00	2,998.00	0.00	0.00	0.00
614	2017067072335	02/17/17 - 03/01/17	03/13/17	0.00	2,458.00	0.00	0.00	0.00
615	2017073014278	02/13/17 - 03/02/17	03/20/17	0.00	2,221.00	0.00	0.00	0.00
614	2017073085846	09/27/16 - 09/29/16	03/20/17	0.00	3,410.00	0.00	0.00	0.00
614	2017075090559	09/11/16 - 09/15/16	03/20/17	0.00	1,287.00	0.00	0.00	0.00
615	5917076001570	02/25/17 - 03/08/17	03/20/17	0.00	2,221.00	0.00	0.00	0.00
614	2017080081948	03/05/17 - 03/10/17	03/27/17	0.00	5,226.00	0.00	0.00	0.00
615	2017095063899	03/15/17 - 03/20/17	04/10/17	0.00	2,209.00	0.00	0.00	0.00
615	2017104081786	03/08/17 - 03/13/17	04/24/17	0.00	2,221.00	0.00	0.00	0.00
614	2017114029214	04/01/17 - 04/06/17	05/01/17	0.00	2,458.00	0.00	0.00	0.00
614	2017125006996	04/15/17 - 04/19/17	05/08/17	0.00	3,410.00	0.00	0.00	0.00
615	2017136006541	04/21/17 - 04/22/17	05/22/17	0.00	2,221.00	0.00	0.00	0.00
614	2017144005175	04/30/17 - 05/03/17	05/29/17	0.00	2,458.00	0.00	0.00	0.00
614	2217152011050	11/27/16 - 12/01/16	06/05/17	0.00	2,669.00	0.00	0.00	0.00
615	2017159102669	05/11/17 - 05/19/17	06/12/17	0.00	2,221.00	0.00	0.00	0.00
615	2017160090055	04/23/17 - 04/24/17	06/19/17	0.00	2,221.00	0.00	0.00	0.00
614	5917191000033	05/13/17 - 05/17/17	07/17/17	0.00	2,458.00	0.00	0.00	0.00
615	2017217027134	06/14/17 - 06/16/17	08/14/17	0.00	2,221.00	0.00	0.00	0.00
614	2017284070664	02/08/17 - 02/13/17	10/16/17	0.00	2,696.00	0.00	0.00	0.00
615	2017362075502	08/13/16 - 08/16/16	01/01/18	0.00	2,221.00	0.00	0.00	0.00

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

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

615	2018067088003	01/06/17 - 01/07/17	03/12/18	0.00	2,221.00	0.00	0.00	0.00
614	2018114077837	05/24/17 - 06/01/17	04/30/18	0.00	1,458.00	0.00	0.00	0.00
615	2018171001148	06/13/17 - 06/20/17	06/25/18	0.00	2,221.00	0.00	0.00	0.00
TOTAL				0.00	126,440.00	0.00	783.66	0.00

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

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

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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	177,884.77	ADJUSTMENTS	0.00
COVERED CHARGES	174,170.77	CONTRACTUAL ALLOW	126,406.40
NON-COVERD CHARGES	3,714.00	TOTAL MEDICAID LIAB	47,764.37
		LESS: COB	47,764.37
		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	14		0	15,428.00		784.00
ROUTINE NURSERY	16		0	26,760.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	30		0	42,188.00		784.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	3,942.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	3,942.00		0.00
TOTAL ACCOMODATIONS	32		0	46,130.00		784.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,276.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,203.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,021.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,939.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,591.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	789.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,973.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,915.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,890.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,674.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,427.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,425.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	832.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,468.16	339.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	444.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,442.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	384.00	0.00			
CARDIOLOGY	1,934.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	128,040.77	2,930.00
			TOTAL ACCOMODATIONS	46,130.00	784.00
			TOTAL CHARGES	174,170.77	3,714.00

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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,887,603.95	ADJUSTMENTS	190,953.47
COVERED CHARGES	11,373,218.82	CONTRACTUAL ALLOW	8,943,924.75
NON-COVERD CHARGES	1,514,385.13	TOTAL MEDICAID LIAB	2,429,294.07
		LESS: COB	9,884.27
		LESS: COPAYMENT	5,158.22
		REIMBURSEMENT	2,414,251.58
		ALL OTHER	2,093,299.83
		FEE SCHEDULE-LAB	194,995.83
		INJECTABLE DRUGS	125,955.92

TOTAL NUMBER OF CLAIMS 5,146

ST MARY'S HOSPITAL
 1230 BAXTER ST
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 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273,794.73	73.30	OTHER LAB	122,656.00	0.00
MED/SURG SUPPLY	191,018.15	104,979.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,580.00	0.00
RADIOLOGY-DIAGNOSTIC	606,166.66	32,627.00	OTHER THERAPEUTIC SVC	0.00	2,027.00
CT SCAN	1,046,014.00	124,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	54,235.00	21,989.00	FEE SCHEDULE LAB	925,045.00	26,478.00
EKG/ECG	191,819.00	14,202.00	MRI SERVICES	636,649.00	50,240.00
IV THERAPY	708,556.00	8,103.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,295,771.86	160,650.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,640.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	109,375.00	4,359.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	431,768.00	16,555.00	AMBULANCE	0.00	845.00
GI SERVICES	221,357.00	58,682.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,990,014.00	7,528.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	460,124.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	738,772.42	278,342.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,182.00	16,475.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	948.00	11,485.50	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	123,388.00	13,140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1.00	255,709.00
LITHOTRIPSY	0.00	15,623.00	NO CC/INVALID REV CODE	0.00	17,775.00
OTHER IMAGING SERVICE	241,321.00	41,964.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,061.00	18,032.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	210,624.00	63,376.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	564,606.00	147,746.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	122,656.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	75,076.00	1,090.00			
			TOTAL ANCILLARY	11,373,218.82	1,514,385.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,373,218.82	1,514,385.13

Report : CLM-0804-0
Process : CLMJ0800
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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016253002668	07/31/16 - 07/31/16	09/12/16	0.00	2,221.00	0.00	0.00	0.00
615	2016278064785	08/17/16 - 08/17/16	10/10/16	0.00	2,221.00	0.00	0.00	0.00
615	2016284031647	09/08/16 - 09/08/16	10/17/16	0.00	2,221.00	0.00	0.00	0.00
615	2016335010168	10/31/16 - 10/31/16	12/05/16	0.00	2,221.00	0.00	0.00	0.00
615	2016335010168	10/31/16 - 10/31/16	12/05/16	0.00	2,209.00	0.00	0.00	0.00
615	5917025000043	11/25/16 - 11/25/16	01/30/17	0.00	2,221.00	0.00	0.00	0.00
615	2017035000780	12/19/16 - 12/19/16	02/13/17	0.00	2,221.00	0.00	0.00	0.00
8100	5917055001857	11/16/16 - 11/16/16	02/27/17	0.00	19.00	0.00	0.00	0.00
615	2017355039319	01/18/17 - 01/18/17	12/25/17	0.00	2,221.00	0.00	0.00	0.00
TOTAL				0.00	17,775.00	0.00	0.00	0.00

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

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	204,488.94	ADJUSTMENTS	0.00
COVERED CHARGES	161,753.49	CONTRACTUAL ALLOW	88,510.38
NON-COVERD CHARGES	42,735.45	TOTAL MEDICAID LIAB	73,243.11
		LESS: COB	73,185.23
		LESS: COPAYMENT	57.88
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 99

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,519.47	0.00	OTHER LAB	1,887.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,734.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,416.00	19,540.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,631.00	679.00
EKG/ECG	4,944.00	0.00	MRI SERVICES	0.00	2,735.00
IV THERAPY	11,493.00	394.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,725.00	8,770.00	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	12,818.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,302.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,723.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,136.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,840.02	478.45
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	4,328.00	106.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,626.00	3,546.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,589.00	4,185.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,381.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,665.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	131.00	0.00			
			TOTAL ANCILLARY	161,753.49	42,735.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	161,753.49	42,735.45

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	657,258.74	ADJUSTMENTS	161.82
COVERED CHARGES	638,377.09	CONTRACTUAL ALLOW	607,274.45
NON-COVERD CHARGES	18,881.65	TOTAL MEDICAID LIAB	31,102.64
		LESS: COB	0.00
		LESS: COPAYMENT	1,083.64
		REIMBURSEMENT	30,019.00
		TOTAL NUMBER OF CLAIMS	556

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,300.19	0.00	OTHER LAB	324.00	0.00
MED/SURG SUPPLY	0.00	2,649.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,244.00	2,777.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,637.00	1,956.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	61,394.00	704.00
EKG/ECG	8,942.00	789.00	MRI SERVICES	2,884.00	0.00
IV THERAPY	59,662.00	1,085.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,010.00	167.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	328,489.00	695.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,445.90	1,973.65
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	106.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,370.00
OTHER IMAGING SERVICE	10,045.00	3,610.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	638,377.09	18,881.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	638,377.09	18,881.65

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
45	2216300013154	07/11/16 - 07/11/16	10/31/16	0.00	149.00	0.00	0.00	0.00
615	2017159000003	05/15/17 - 05/15/17	06/12/17	0.00	2,221.00	0.00	0.00	0.00
TOTAL				0.00	2,370.00	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
 SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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ST MARY'S HOSPITAL
 1230 BAXTER ST
 ATHENS,GA 30606-3712

PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
000001823A	SERVICE DATES	07/01/16	THROUGH	06/30/17
	ADMISSION DATES	00/00/00	THROUGH	00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,107.60	ADJUSTMENTS	0.00
COVERED CHARGES	14,701.60	CONTRACTUAL ALLOW	9,685.24
NON-COVERD CHARGES	1,406.00	TOTAL MEDICAID LIAB	5,016.36
		LESS: COB	5,013.36
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,119.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,635.00	33.00
EKG/ECG	263.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,124.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,257.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	437.75	38.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	827.00	1,335.00			
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	0.00	0.00			
			TOTAL ANCILLARY	14,701.60	1,406.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,701.60	1,406.00

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

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

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

ST MARY'S HOSPITAL
1230 BAXTER ST
ATHENS,GA 30606-3712

PROVIDER NUMBER
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,111,756.30	ADJUSTMENTS	10,869.20
COVERED CHARGES	1,019,457.86	CONTRACTUAL ALLOW	790,952.66
NON-COVERD CHARGES	92,298.44	TOTAL MEDICAID LIAB	228,505.20
		LESS: COB	0.00
		LESS: COPAYMENT	227.88
		REIMBURSEMENT	228,277.32

TOTAL NUMBER OF CLAIMS 42

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,142.64	0.00	OTHER LAB	915.00	0.00
MED/SURG SUPPLY	50,237.00	22,557.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,191.00	313.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,607.00	2,591.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	817.00	FEE SCHEDULE LAB	12,358.00	302.00
EKG/ECG	3,682.00	526.00	MRI SERVICES	2,884.00	0.00
IV THERAPY	21,285.00	785.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	219,950.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,000.00	167.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	65,374.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,551.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,524.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	433,036.22	13,028.44
RADIOLOGY THERAPEUTIC	641.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	457.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	336.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	293.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,960.00	35,816.00
LITHOTRIPSY	15,623.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,105.00	835.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,714.00	676.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	76,881.00	12,254.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,939.00	545.00			
			TOTAL ANCILLARY	1,019,457.86	92,298.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,019,457.86	92,298.44

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

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

Run Date: 08/28/2018
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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER 000001834A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,596,796.23	ADJUSTMENTS	4,608.99
COVERED CHARGES	2,528,617.37	CONTRACTUAL ALLOW	1,654,602.32
NON-COVERD CHARGES	68,178.86	TOTAL MEDICAID LIAB	874,015.05
		LESS: COB	2,191.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	871,823.25

TOTAL NUMBER OF ADMISSIONS 117

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	414		1	253,170.00		56,020.00
ROUTINE NURSERY	18		0	9,180.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	432		1	262,350.00		56,020.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	112		0	179,025.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	112		0	179,025.00		0.00
TOTAL ACCOMODATIONS	544		1	441,375.00		56,020.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	379,654.49	0.00	OTHER LAB	7,922.40	0.00
MED/SURG SUPPLY	635,222.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	162,176.83	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,331.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,761.55	5,860.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,116.60	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,514.20	0.00	MRI SERVICES	9,159.95	0.00
IV THERAPY	11,110.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	153,821.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,703.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	208,254.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,485.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,311.20	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,212.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,484.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,542.25	0.00	INJECTABLE DRUGS	12,274.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,397.60	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	133.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,194.50	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	46,671.91	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,065.60
OTHER IMAGING SERVICE	4,070.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,017.10	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,655.85	4,232.91			
AUDIOLOGY	583.60	0.00			
CARDIOLOGY	24,430.75	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	53,025.18	0.00			
			TOTAL ANCILLARY	2,087,242.37	12,158.86
			TOTAL ACCOMODATIONS	441,375.00	56,020.00
			TOTAL CHARGES	2,528,617.37	68,178.86

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: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017073057710	01/25/17 - 02/08/17	03/20/17	0.00	2,065.60	0.00	0.00	0.00
TOTAL				0.00	2,065.60	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

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER 000001834A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,009.69	ADJUSTMENTS	0.00
COVERED CHARGES	21,709.69	CONTRACTUAL ALLOW	5,998.50
NON-COVERD CHARGES	300.00	TOTAL MEDICAID LIAB	15,711.19
		LESS: COB	15,711.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6		0	3,630.00		300.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6		0	3,630.00		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	3,630.00		300.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,858.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,842.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,988.02	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	589.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	1,606.60	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,449.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	482.05	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	776.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	240.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	512.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	472.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,606.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,655.85	0.00			
			TOTAL ANCILLARY	18,079.69	0.00
			TOTAL ACCOMODATIONS	3,630.00	300.00
			TOTAL CHARGES	21,709.69	300.00

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: 08/28/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,422,775.97	ADJUSTMENTS	174,706.78
COVERED CHARGES	1,915,213.62	CONTRACTUAL ALLOW	1,170,038.92
NON-COVERD CHARGES	507,562.35	TOTAL MEDICAID LIAB	745,174.70
		LESS: COB	1,888.91
		LESS: COPAYMENT	2,116.68
		REIMBURSEMENT	741,169.11
		ALL OTHER	687,233.27
		FEE SCHEDULE-LAB	53,180.41
		INJECTABLE DRUGS	755.43
		TOTAL NUMBER OF CLAIMS	1,857

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,994.07	19,722.71	OTHER LAB	74,080.65	0.00
MED/SURG SUPPLY	221,903.63	241.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	63.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,616.75	20,812.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	205,574.30	66,812.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,076.40	3,538.95	FEE SCHEDULE LAB	224,883.25	9,929.21
EKG/ECG	33,309.90	3,650.40	MRI SERVICES	63,075.10	6,851.05
IV THERAPY	31,381.70	4,595.55	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,314.85	26,325.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	720.95	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,194.65	9,213.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,345.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,461.28	5,281.63	CAST ROOM	0.00	0.00
EMERGENCY ROOM	343,542.05	29,490.85	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,651.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,105.15	5,526.13
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	206.40	1,065.60	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,425.80	1,117.65	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	113.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	12,103.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	51,232.75	5,414.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,017.50	2,542.15			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,102.90	38,025.71			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,349.70	1,997.95			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	237,646.74	233,126.44			
			TOTAL ANCILLARY	1,915,213.62	507,562.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,915,213.62	507,562.35

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,203.08	ADJUSTMENTS	0.00
COVERED CHARGES	40,399.99	CONTRACTUAL ALLOW	9,677.46
NON-COVERD CHARGES	7,803.09	TOTAL MEDICAID LIAB	30,722.53
		LESS: COB	30,665.53
		LESS: COPAYMENT	57.00
		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

STEPHENS COUNTY HOSPITAL
 163 HOSPITAL DR
 TOCCOA,GA 30577-6820

PROVIDER NUMBER
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,468.35	306.14	OTHER LAB	3,703.70	0.00
MED/SURG SUPPLY	2,517.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	722.40	140.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,594.15	3,234.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,826.23	160.60
EKG/ECG	228.15	0.00	MRI SERVICES	3,435.85	0.00
IV THERAPY	1,290.00	160.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	163.70	535.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,616.55	249.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,155.75	576.30			
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	1,632.45			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,677.75	807.45			
			TOTAL ANCILLARY	40,399.99	7,803.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,399.99	7,803.09

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

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

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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	222,075.42	ADJUSTMENTS	744.16
COVERED CHARGES	195,571.60	CONTRACTUAL ALLOW	175,209.44
NON-COVERD CHARGES	26,503.82	TOTAL MEDICAID LIAB	20,362.16
		LESS: COB	0.00
		LESS: COPAYMENT	750.00
		REIMBURSEMENT	19,612.16
		TOTAL NUMBER OF CLAIMS	364

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,509.71	1,811.15	OTHER LAB	2,096.75	0.00
MED/SURG SUPPLY	5,994.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,021.55	2,437.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,966.75	13,082.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,553.46	818.27
EKG/ECG	4,791.15	228.15	MRI SERVICES	0.00	0.00
IV THERAPY	2,088.30	255.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	288.65	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.15	4,331.40	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	114,250.10	2,313.55	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	576.30	558.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,224.35	668.45			
			TOTAL ANCILLARY	195,571.60	26,503.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	195,571.60	26,503.82

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,196.30	ADJUSTMENTS	0.00
COVERED CHARGES	3,056.50	CONTRACTUAL ALLOW	100.53
NON-COVERD CHARGES	2,139.80	TOTAL MEDICAID LIAB	2,955.97
		LESS: COB	2,949.97
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24.83	8.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	75.75	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	2,131.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	547.62	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,850.25	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	558.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,056.50	2,139.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,056.50	2,139.80

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

STEPHENS COUNTY HOSPITAL
163 HOSPITAL DR
TOCCOA,GA 30577-6820

PROVIDER NUMBER
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	456,886.65	ADJUSTMENTS	60,976.53
COVERED CHARGES	434,984.34	CONTRACTUAL ALLOW	307,444.05
NON-COVERD CHARGES	21,902.31	TOTAL MEDICAID LIAB	127,540.29
		LESS: COB	0.00
		LESS: COPAYMENT	135.00
		REIMBURSEMENT	127,405.29
		TOTAL NUMBER OF CLAIMS	23

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,212.24	4,582.73	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	172,114.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,581.15	1,511.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,802.25	1,914.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,599.87	20.90
EKG/ECG	228.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	210.00	1,088.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	98,798.79	10,475.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,416.90	200.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,033.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,614.55	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,529.95	1,369.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,217.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	500.65	269.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,124.30	469.30			
			TOTAL ANCILLARY	434,984.34	21,902.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	434,984.34	21,902.31

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

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

Run Date: 08/28/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/28/2018
 Run Time: 23:38:59
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,058,607.74	ADJUSTMENTS	540,381.53
COVERED CHARGES	19,023,909.60	CONTRACTUAL ALLOW	13,330,623.09
NON-COVERD CHARGES	34,698.14	TOTAL MEDICAID LIAB	5,693,286.51
		LESS: COB	33,941.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,659,344.58

TOTAL NUMBER OF ADMISSIONS 564

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,437		0	1,745,224.00		7,574.00
ROUTINE NURSERY	176		0	128,128.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,613		0	1,873,352.00		7,574.00
SPECIAL CARE SERVICES						
CCU	762		0	1,386,931.00		0.00
ICU	241		0	683,136.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,003		0	2,070,067.00		0.00
TOTAL ACCOMODATIONS	2,616		0	3,943,419.00		7,574.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,743,591.85	546.00	OTHER LAB	99,679.00	0.00
MED/SURG SUPPLY	1,080,942.10	1,836.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,167,040.64	4,848.00	EDUCATION & TRAINING	9,650.00	0.00
RADIOLOGY-DIAGNOSTIC	250,048.74	2,888.64	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	722,877.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	181,325.67	1,430.04	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	156,712.00	0.00	MRI SERVICES	211,209.00	0.00
IV THERAPY	361,858.25	1,395.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,958,126.10	1,885.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	215,311.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,055,324.00	12,135.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	292,791.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	190,825.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	700,645.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,805.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	63,335.92	0.00	INJECTABLE DRUGS	852,762.69	0.00
RADIOLOGY THERAPEUTIC	48,594.21	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,970.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,873.20	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	135,912.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,830.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	814,296.45	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54,011.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	243,641.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	136,065.00	0.00			
AUDIOLOGY	10,540.00	0.00			
CARDIOLOGY	1,054,574.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,782.23	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142,540.35	160.00			
			TOTAL ANCILLARY	15,080,490.60	27,124.14
			TOTAL ACCOMODATIONS	3,943,419.00	7,574.00
			TOTAL CHARGES	19,023,909.60	34,698.14

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

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

Run Date: 08/28/2018
 Run Time: 23:39:16
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	149,723.10	ADJUSTMENTS	0.00
COVERED CHARGES	149,723.10	CONTRACTUAL ALLOW	44,392.29
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	105,330.81
		LESS: COB	105,330.81
		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	9		0	10,998.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	10,998.00		0.00
SPECIAL CARE SERVICES						
CCU	2		0	3,640.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	3,640.00		0.00
TOTAL ACCOMODATIONS	11		0	14,638.00		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,553.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,019.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,866.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	570.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,943.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	815.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,347.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,399.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,544.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,345.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,446.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,555.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	405.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	30,350.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,034.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,310.33	0.00			
			TOTAL ANCILLARY	135,085.10	0.00
			TOTAL ACCOMODATIONS	14,638.00	0.00
			TOTAL CHARGES	149,723.10	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: 08/28/2018
Run Time: 23:39:16
Page: 5

TANNER MEDICAL CENTER - CARROLLTON
705 DIXIE ST
CARROLLTON,GA 30117-3818

PROVIDER NUMBER
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,585,619.06	ADJUSTMENTS	565,340.89
COVERED CHARGES	18,731,974.84	CONTRACTUAL ALLOW	15,052,388.12
NON-COVERD CHARGES	853,644.22	TOTAL MEDICAID LIAB	3,679,586.72
		LESS: COB	2,596.33
		LESS: COPAYMENT	9,528.00
		REIMBURSEMENT	3,667,462.39
		ALL OTHER	3,295,806.34
		FEE SCHEDULE-LAB	193,995.37
		INJECTABLE DRUGS	177,660.68

TOTAL NUMBER OF CLAIMS 6,516

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	676,331.76	309.37	OTHER LAB	146,135.00	1,414.00
MED/SURG SUPPLY	180,713.87	39.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	2,915.00
RADIOLOGY-DIAGNOSTIC	735,010.15	32,572.56	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,174,883.00	155,198.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,570.00	8,420.00	FEE SCHEDULE LAB	2,121,349.36	22,065.23
EKG/ECG	256,711.00	5,582.00	MRI SERVICES	569,568.00	54,368.00
IV THERAPY	1,330,762.00	29,119.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,245,501.12	79,178.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	825.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	291,554.00	7,273.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	271,517.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	364,621.00	8,667.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,307,629.54	6,774.76	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,330.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	847,878.86	34,252.93
RADIOLOGY THERAPEUTIC	758,750.55	36,158.02	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	590.00	1,110.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,964.00	3,483.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,728.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	419,788.94	35,498.77	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	376,960.00	620.00	IMPL DEV CHARGE PATIENTS	109,989.97	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	558,981.00	48,545.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	71,019.00	1,394.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	334,109.08	63,424.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	611,938.53	88,285.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	307,972.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	606,021.11	119,249.63			
			TOTAL ANCILLARY	18,731,974.84	853,644.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,731,974.84	853,644.22

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	299,665.13	ADJUSTMENTS	0.00
COVERED CHARGES	185,734.29	CONTRACTUAL ALLOW	8,155.66
NON-COVERD CHARGES	113,930.84	TOTAL MEDICAID LIAB	177,578.63
		LESS: COB	177,500.63
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 76

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,195.84	63.00	OTHER LAB	5,753.00	0.00
MED/SURG SUPPLY	2,682.96	458.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,676.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,180.00	18,585.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	425.00	FEE SCHEDULE LAB	23,545.35	1,580.00
EKG/ECG	1,474.00	241.00	MRI SERVICES	3,873.00	3,236.00
IV THERAPY	20,704.00	300.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,350.50	20,969.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,365.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,405.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,165.62	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,295.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,154.21	25,174.88
RADIOLOGY THERAPEUTIC	3,811.07	18,070.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	497.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	948.00	1,015.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	14,880.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,594.51
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,464.00
OTHER IMAGING SERVICE	4,375.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,164.00	850.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,595.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,026.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,213.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,752.78	13,381.68			
			TOTAL ANCILLARY	185,734.29	113,930.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	185,734.29	113,930.84

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017142030176	01/24/17 - 01/24/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	01/25/17 - 01/25/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	01/26/17 - 01/26/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	01/27/17 - 01/27/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	01/30/17 - 01/30/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	01/31/17 - 01/31/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	02/01/17 - 02/01/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	02/02/17 - 02/02/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	02/03/17 - 02/03/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	02/06/17 - 02/06/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	02/07/17 - 02/07/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
905	2017142030176	02/08/17 - 02/08/17	05/29/17	0.00	372.00	0.00	6,856.59	0.00
TOTAL				0.00	4,464.00	0.00	82,279.08	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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	935,851.70	ADJUSTMENTS	594.34
COVERED CHARGES	927,990.19	CONTRACTUAL ALLOW	896,160.33
NON-COVERD CHARGES	7,861.51	TOTAL MEDICAID LIAB	31,829.86
		LESS: COB	26.25
		LESS: COPAYMENT	932.93
		REIMBURSEMENT	30,870.68
		TOTAL NUMBER OF CLAIMS	569

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,194.09	0.00	OTHER LAB	2,532.00	0.00
MED/SURG SUPPLY	1,053.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,188.96	2,567.68	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	128,563.00	1,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	141,680.46	2,126.00
EKG/ECG	11,506.00	241.00	MRI SERVICES	0.00	0.00
IV THERAPY	69,882.75	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	6,600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	411,239.53	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,693.74	513.83
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	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	16,280.00	450.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,575.70	0.00			
			TOTAL ANCILLARY	927,990.19	7,861.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	927,990.19	7,861.51

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,116.57	ADJUSTMENTS	0.00
COVERED CHARGES	33,668.57	CONTRACTUAL ALLOW	29,042.27
NON-COVERD CHARGES	1,448.00	TOTAL MEDICAID LIAB	4,626.30
		LESS: COB	4,564.36
		LESS: COPAYMENT	61.94
		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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,760.11	117.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	7,271.00	66.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,253.75	715.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,597.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	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	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	545.00	0.00			
			TOTAL ANCILLARY	33,668.57	1,448.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,668.57	1,448.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,801,727.37	ADJUSTMENTS	265,909.82
COVERED CHARGES	6,577,591.38	CONTRACTUAL ALLOW	5,681,137.16
NON-COVERD CHARGES	224,135.99	TOTAL MEDICAID LIAB	896,454.22
		LESS: COB	0.00
		LESS: COPAYMENT	1,686.00
		REIMBURSEMENT	894,768.22
		TOTAL NUMBER OF CLAIMS	155

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	248,898.81	0.00	OTHER LAB	5,800.00	0.00
MED/SURG SUPPLY	197,722.64	6,400.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	435.00
RADIOLOGY-DIAGNOSTIC	39,613.00	5,751.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,927.00	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	425.00	2,150.00	FEE SCHEDULE LAB	85,890.08	1,767.00
EKG/ECG	13,882.00	723.00	MRI SERVICES	0.00	0.00
IV THERAPY	287,996.00	8,297.92	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	374,186.50	43,689.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,163.00	9,290.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,528.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,509.17	245.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,825.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,386,098.55	14,070.47
RADIOLOGY THERAPEUTIC	951,054.77	16,928.84	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	425.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	664.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	318,583.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,416.00	713.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,164.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,475.00	9,570.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	397,178.40	74,674.09			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	96,743.26	18,123.21			
			TOTAL ANCILLARY	6,577,591.38	224,135.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,577,591.38	224,135.99

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,304.67	ADJUSTMENTS	0.00
COVERED CHARGES	29,405.61	CONTRACTUAL ALLOW	-12,043.73
NON-COVERD CHARGES	26,899.06	TOTAL MEDICAID LIAB	41,449.34
		LESS: COB	41,440.34
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,896.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	258.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	651.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	555.00	FEE SCHEDULE LAB	415.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,856.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,171.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,760.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	230.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	168.00	146.30
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	22,595.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	3,602.76			
			TOTAL ANCILLARY	29,405.61	26,899.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,405.61	26,899.06

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

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

Run Date: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,724,922.77	ADJUSTMENTS	1,071,005.79
COVERED CHARGES	48,385,253.18	CONTRACTUAL ALLOW	33,490,562.89
NON-COVERD CHARGES	339,669.59	TOTAL MEDICAID LIAB	14,894,690.29
		LESS: COB	219,739.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,674,950.35

TOTAL NUMBER OF ADMISSIONS 1,359

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,334		0	1,927,340.00		6,380.00
ROUTINE NURSERY	714		0	755,448.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		69,629.01
TOTAL ROUTINE	4,048		0	2,682,788.00		76,009.01
SPECIAL CARE SERVICES						
CCU	82		0	133,250.00		0.00
ICU	4,306		0	4,529,704.00		7,412.00
NICU	155		0	251,875.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,543		0	4,914,829.00		7,412.00
TOTAL ACCOMODATIONS	8,591		0	7,597,617.00		83,421.01

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,148,599.16	20,196.40	OTHER LAB	327,149.00	0.00
MED/SURG SUPPLY	7,107,655.56	49,080.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,257,312.96	6,675.18	EDUCATION & TRAINING	23,578.00	0.00
RADIOLOGY-DIAGNOSTIC	991,736.00	2,131.00	OTHER THERAPEUTIC SVC	65,636.00	18,851.00
CT SCAN	2,359,175.00	3,552.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	295,759.00	1,584.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	308,881.00	0.00	MRI SERVICES	670,784.00	0.00
IV THERAPY	278,823.00	1,875.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,752,026.00	2,531.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,351.00	0.00	REHAB THERAPY	2,715.00	0.00
RESPIRATORY SERVICES	2,597,033.00	8,818.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	220,515.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	252,456.00	0.00	CAST ROOM	198.00	0.00
EMERGENCY ROOM	1,119,902.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	203,955.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	193,071.63	0.00	INJECTABLE DRUGS	2,468.63	0.00
RADIOLOGY THERAPEUTIC	5,286.84	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	170,372.00	675.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	61,514.00	879.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	432,540.00	23,490.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	31,752.00	5,727.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,476,160.17	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	16,118.00
OTHER IMAGING SERVICE	199,068.00	4,900.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	594,700.23	10,389.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	286,216.00	74,866.00			
AUDIOLOGY	16,698.00	0.00			
CARDIOLOGY	1,810,268.00	1,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	39,036.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	423,245.00	2,202.00			
			TOTAL ANCILLARY	40,787,636.18	256,248.58
			TOTAL ACCOMODATIONS	7,597,617.00	83,421.01
			TOTAL CHARGES	48,385,253.18	339,669.59

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: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017137056506	04/14/17 - 04/20/17	05/22/17	0.00	3,053.00	0.00	0.00	0.00
615	2017163009636	05/23/17 - 05/27/17	06/19/17	0.00	2,613.00	0.00	0.00	0.00
615	2017275001768	06/20/17 - 06/24/17	10/09/17	0.00	2,613.00	0.00	0.00	0.00
615	5918058000831	10/15/17 - 10/16/17	03/05/18	0.00	2,613.00	0.00	0.00	0.00
615	2318085000126	11/09/17 - 11/18/17	04/16/18	0.00	2,613.00	0.00	6,296.06	0.00
615	9818117000022	09/04/17 - 10/10/17	05/07/18	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	16,118.00	0.00	6,296.06	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: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	998,226.62	ADJUSTMENTS	0.00
COVERED CHARGES	998,002.62	CONTRACTUAL ALLOW	489,052.56
NON-COVERD CHARGES	224.00	TOTAL MEDICAID LIAB	508,950.06
		LESS: COB	508,950.06
		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	61		0	35,380.00		0.00
ROUTINE NURSERY	16		0	15,383.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	77		0	50,763.00		0.00
SPECIAL CARE SERVICES						
CCU	1		0	1,625.00		0.00
ICU	26		0	26,500.00		0.00
NICU	79		0	138,125.00		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	106		0	166,250.00		0.00
TOTAL ACCOMODATIONS	183		0	217,013.00		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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,351.72	0.00	OTHER LAB	2,014.00	0.00
MED/SURG SUPPLY	161,531.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	76,555.75	0.00	EDUCATION & TRAINING	166.00	0.00
RADIOLOGY-DIAGNOSTIC	15,636.00	0.00	OTHER THERAPEUTIC SVC	174.00	224.00
CT SCAN	3,552.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,346.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,620.00	0.00	MRI SERVICES	2,722.00	0.00
IV THERAPY	2,214.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,719.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,421.00	0.00	REHAB THERAPY	30.00	0.00
RESPIRATORY SERVICES	154,659.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,210.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,838.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,605.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,214.80	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	492.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,792.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,050.00	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	29,018.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,019.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,813.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	824.00	0.00			
CARDIOLOGY	62,471.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	712.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,840.00	0.00			
			TOTAL ANCILLARY	780,989.62	224.00
			TOTAL ACCOMODATIONS	217,013.00	0.00
			TOTAL CHARGES	998,002.62	224.00

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: 08/28/2018
Run Time: 23:50:53
Page: 6

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,950,080.28	ADJUSTMENTS	827,353.45
COVERED CHARGES	19,824,615.63	CONTRACTUAL ALLOW	15,889,045.63
NON-COVERD CHARGES	1,125,464.65	TOTAL MEDICAID LIAB	3,935,570.00
		LESS: COB	31,032.43
		LESS: COPAYMENT	13,761.00
		REIMBURSEMENT	3,890,776.57
		ALL OTHER	2,898,256.15
		FEE SCHEDULE-LAB	437,661.75
		INJECTABLE DRUGS	554,858.67
		TOTAL NUMBER OF CLAIMS	11,874

UNIVERSITY HOSPITAL
 1350 WALTON WAY
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	900,211.44	1,409.00	OTHER LAB	440,481.00	133.00
MED/SURG SUPPLY	1,818,522.44	8,954.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	217.00	1,672.00
RADIOLOGY-DIAGNOSTIC	856,557.00	18,038.00	OTHER THERAPEUTIC SVC	336.00	213.00
CT SCAN	2,465,168.00	222,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,220.00	10,605.00	FEE SCHEDULE LAB	2,684,073.97	32,654.29
EKG/ECG	339,556.00	3,668.00	MRI SERVICES	589,875.00	38,849.00
IV THERAPY	1,046,797.00	12,639.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,089,336.06	141,371.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50,042.00	0.00	REHAB THERAPY	15.00	612.00
RESPIRATORY SERVICES	107,097.00	4,317.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	102,913.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	175,242.50	28,180.50	CAST ROOM	9,190.00	0.00
EMERGENCY ROOM	2,668,217.00	539.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	166,912.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	242.77
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,840,761.30	380,102.58
RADIOLOGY THERAPEUTIC	21,531.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,342.00	7,901.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,807.00	4,297.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,290.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	259,177.00	29,284.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,398.93	5,238.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,226.00
OTHER IMAGING SERVICE	505,261.00	45,477.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	88,777.99	1,176.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	464,693.00	25,058.00			
AUDIOLOGY	244.00	256.00			
CARDIOLOGY	691,578.00	83,200.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,152.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	323,913.00	3,937.00			
			TOTAL ANCILLARY	19,824,615.63	1,125,464.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,824,615.63	1,125,464.65

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: 08/28/2018
Run Time: 23:50:53
Page: 8

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9718046981006	08/22/17 - 08/22/17	02/19/18	0.00	2,613.00	0.00	0.00	0.00
615	5918221001412	09/16/17 - 09/16/17	08/13/18	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	5,226.00	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: 08/28/2018
Run Time: 23:52:24
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	226,396.25	ADJUSTMENTS	0.00
COVERED CHARGES	194,837.73	CONTRACTUAL ALLOW	120,335.73
NON-COVERD CHARGES	31,558.52	TOTAL MEDICAID LIAB	74,502.00
		LESS: COB	74,427.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 93

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

UNIVERSITY HOSPITAL
 1350 WALTON WAY
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,935.01	105.98	OTHER LAB	823.00	0.00
MED/SURG SUPPLY	19,917.35	3,136.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,621.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,084.00	3,736.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,071.98	1,971.50
EKG/ECG	4,192.00	0.00	MRI SERVICES	5,764.00	110.00
IV THERAPY	12,689.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,315.66	1,909.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,010.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	498.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,792.00	396.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,586.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,939.73	1,003.70
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	563.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	776.00	189.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	69.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,014.00	17,052.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,216.00	240.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,499.00	1,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,462.00	0.00			
			TOTAL ANCILLARY	194,837.73	31,558.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	194,837.73	31,558.52

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: 08/28/2018
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Page: 11

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	322,075.64	ADJUSTMENTS	488.46
COVERED CHARGES	311,090.59	CONTRACTUAL ALLOW	289,547.71
NON-COVERD CHARGES	10,985.05	TOTAL MEDICAID LIAB	21,542.88
		LESS: COB	729.82
		LESS: COPAYMENT	731.32
		REIMBURSEMENT	20,081.74
		TOTAL NUMBER OF CLAIMS	373

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,241.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,718.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,100.00	926.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,739.00	7,472.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	64,880.33	432.52
EKG/ECG	8,908.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,295.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	145,955.00	592.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,908.90	376.53
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	4,344.00	1,186.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	311,090.59	10,985.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	311,090.59	10,985.05

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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,705.83	ADJUSTMENTS	0.00
COVERED CHARGES	6,909.83	CONTRACTUAL ALLOW	2,905.93
NON-COVERD CHARGES	1,796.00	TOTAL MEDICAID LIAB	4,003.90
		LESS: COB	3,997.90
		LESS: COPAYMENT	6.00
		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

UNIVERSITY HOSPITAL
 1350 WALTON WAY
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311.09	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	488.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,776.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	782.56	20.00
EKG/ECG	524.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	567.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,853.00	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	384.18	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,909.83	1,796.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,909.83	1,796.00

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

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

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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,928,003.87	ADJUSTMENTS	135,773.26
COVERED CHARGES	3,191,474.53	CONTRACTUAL ALLOW	2,549,938.90
NON-COVERD CHARGES	736,529.34	TOTAL MEDICAID LIAB	641,535.63
		LESS: COB	0.00
		LESS: COPAYMENT	408.00
		REIMBURSEMENT	641,127.63
		TOTAL NUMBER OF CLAIMS	118

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,150.03	0.00	OTHER LAB	1,527.00	0.00
MED/SURG SUPPLY	456,370.45	178,895.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	156.00	0.00
RADIOLOGY-DIAGNOSTIC	74,591.00	2,913.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,776.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	312.00	FEE SCHEDULE LAB	28,080.87	690.00
EKG/ECG	5,764.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	51,742.00	1,323.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	497,621.60	395,385.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,130.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,212.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,847.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,057,568.98	76,612.64
RADIOLOGY THERAPEUTIC	189.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	935.00	756.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	713,398.60	41,247.64
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,066.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	314.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,942.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	207,931.00	33,832.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,864.00	1,620.00			
			TOTAL ANCILLARY	3,191,474.53	736,529.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,191,474.53	736,529.34

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

UNIVERSITY HOSPITAL
1350 WALTON WAY
AUGUSTA,GA 30901-2612

PROVIDER NUMBER
000001977A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/28/2018
 Run Time: 23:24:33
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER
 801 W GORDON ST
 THOMASTON,GA 30286-3426

PROVIDER NUMBER 000001988A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,341,796.25	ADJUSTMENTS	83,848.28
COVERED CHARGES	10,299,890.10	CONTRACTUAL ALLOW	7,215,526.36
NON-COVERD CHARGES	41,906.15	TOTAL MEDICAID LIAB	3,084,363.74
		LESS: COB	28,482.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,055,881.64

TOTAL NUMBER OF ADMISSIONS 320

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	593		0	633,324.00		12,690.00
ROUTINE NURSERY	37		0	30,599.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		3,204.00
TOTAL ROUTINE	630		0	663,923.00		15,894.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	553		0	1,228,721.00		0.00
NICU	5		0	7,855.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	558		0	1,236,576.00		0.00
TOTAL ACCOMODATIONS	1,188		0	1,900,499.00		15,894.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	397,555.66	0.00	OTHER LAB	19,977.00	0.00
MED/SURG SUPPLY	469,765.17	295.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	962,717.73	0.00	EDUCATION & TRAINING	112.00	0.00
RADIOLOGY-DIAGNOSTIC	206,245.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	666,024.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	173,537.60	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	106,594.00	0.00	MRI SERVICES	93,677.00	0.00
IV THERAPY	206,493.00	0.00	PROFESSIONAL FEES	0.00	410.00
OPERATING ROOM	1,436,760.00	0.00	DURABLE MED. EQUIP.	0.00	290.52
LABOR/DELIVERY ROOM	51,288.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,013,491.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	81,336.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	93,232.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	460,204.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	251,408.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	13,790.70
LABORATORY PATHOLOGIC	32,622.00	0.00	INJECTABLE DRUGS	778,114.04	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	1,633.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	102,250.00	2,045.00	PATIENT CONVENIENCE	0.00	36.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,770.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	470,676.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,249.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	114,681.00	784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,042.00	7,827.00			
AUDIOLOGY	1,548.00	533.93			
CARDIOLOGY	116,742.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,337.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,309.00	0.00			
			TOTAL ANCILLARY	8,399,391.10	26,012.15
			TOTAL ACCOMODATIONS	1,900,499.00	15,894.00
			TOTAL CHARGES	10,299,890.10	41,906.15

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,770.12	ADJUSTMENTS	0.00
COVERED CHARGES	32,770.12	CONTRACTUAL ALLOW	12,517.92
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	20,252.20
		LESS: COB	20,252.20
		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	5		0	5,340.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	5,340.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	5,340.00		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: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	489.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	751.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,989.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	758.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,413.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	653.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,532.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,689.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,061.80	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	1,093.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,430.12	0.00
			TOTAL ACCOMODATIONS	5,340.00	0.00
			TOTAL CHARGES	32,770.12	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: 08/28/2018
Run Time: 23:24:50
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,645,200.50	ADJUSTMENTS	613,928.69
COVERED CHARGES	12,077,297.78	CONTRACTUAL ALLOW	10,262,067.36
NON-COVERD CHARGES	567,902.72	TOTAL MEDICAID LIAB	1,815,230.42
		LESS: COB	536.20
		LESS: COPAYMENT	4,113.53
		REIMBURSEMENT	1,810,580.69
		ALL OTHER	1,629,251.47
		FEE SCHEDULE-LAB	162,029.22
		INJECTABLE DRUGS	19,300.00

TOTAL NUMBER OF CLAIMS 3,891

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,737.69	9,829.62	OTHER LAB	78,733.00	4,177.00
MED/SURG SUPPLY	289,222.84	10,968.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	350.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	614,866.00	11,537.00	OTHER THERAPEUTIC SVC	0.00	1,739.00
CT SCAN	2,074,759.00	79,223.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	78,681.00	28,881.07	FEE SCHEDULE LAB	1,729,861.00	23,050.00
EKG/ECG	276,557.00	7,582.00	MRI SERVICES	230,079.00	9,880.00
IV THERAPY	556,800.50	15,995.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,629,283.93	209,139.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,572.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,139.00	4,725.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	108,359.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	179,326.00	9,841.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,521,727.00	6,013.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	352,768.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	268,629.18	53,485.59
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	217.00	1,611.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,090.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,100.00	6,380.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	112,634.64	7,278.62
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	173,759.00	16,389.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,701.00	4,063.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,509.00	18,260.00			
AUDIOLOGY	0.00	421.63			
CARDIOLOGY	69,622.00	15,338.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	96,155.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	319,499.00	7,655.00			
			TOTAL ANCILLARY	12,077,297.78	567,902.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,077,297.78	567,902.72

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: 08/28/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,789.46	ADJUSTMENTS	0.00
COVERED CHARGES	95,889.23	CONTRACTUAL ALLOW	43,872.85
NON-COVERD CHARGES	24,900.23	TOTAL MEDICAID LIAB	52,016.38
		LESS: COB	51,973.09
		LESS: COPAYMENT	43.29
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6.25	30.53	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	639.32	162.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,992.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,853.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,900.00	1,179.00	FEE SCHEDULE LAB	16,679.00	322.00
EKG/ECG	2,230.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,813.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,480.00	14,350.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,437.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,819.00	490.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,892.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,306.66	846.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,822.00	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	14,751.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,122.00	0.00			
			TOTAL ANCILLARY	95,889.23	24,900.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	95,889.23	24,900.23

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

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

Run Date: 08/28/2018
Run Time: 23:25:54
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	425,271.40	ADJUSTMENTS	1,175.09
COVERED CHARGES	418,718.37	CONTRACTUAL ALLOW	400,370.05
NON-COVERD CHARGES	6,553.03	TOTAL MEDICAID LIAB	18,348.32
		LESS: COB	0.00
		LESS: COPAYMENT	717.55
		REIMBURSEMENT	17,630.77
		TOTAL NUMBER OF CLAIMS	328

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

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

Run Date: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,385.51	531.45	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,077.56	250.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,967.00	466.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,495.00	3,136.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	46,881.00	36.00
EKG/ECG	5,798.00	0.00	MRI SERVICES	5,078.00	0.00
IV THERAPY	27,459.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	288.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	479.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,936.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	274,070.00	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	6,694.30	1,039.66
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	2,110.00	1,093.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	418,718.37	6,553.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	418,718.37	6,553.03

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

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

Run Date: 08/28/2018
Run Time: 23:26:00
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,992.61	ADJUSTMENTS	0.00
COVERED CHARGES	13,911.11	CONTRACTUAL ALLOW	7,853.59
NON-COVERD CHARGES	81.50	TOTAL MEDICAID LIAB	6,057.52
		LESS: COB	6,045.52
		LESS: COPAYMENT	12.00
		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: 08/28/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.90	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	379.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,534.00	0.00
EKG/ECG	446.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,500.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,775.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	273.21	81.50
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	13,911.11	81.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,911.11	81.50

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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	814,186.64	ADJUSTMENTS	60,132.19
COVERED CHARGES	767,763.41	CONTRACTUAL ALLOW	668,742.61
NON-COVERD CHARGES	46,423.23	TOTAL MEDICAID LIAB	99,020.80
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	98,918.80

TOTAL NUMBER OF CLAIMS 18

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,070.98	726.39	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	68,333.09	171.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,695.00	13,365.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	916.03	FEE SCHEDULE LAB	12,704.00	96.00
EKG/ECG	2,036.00	446.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,904.00	178.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	358,500.33	24,806.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,939.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,954.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,764.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,564.21	3,869.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	111,225.80	0.00
LITHOTRIPSY	112,194.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,090.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,789.00	1,848.00			
			TOTAL ANCILLARY	767,763.41	46,423.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	767,763.41	46,423.23

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: 08/28/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER
801 W GORDON ST
THOMASTON,GA 30286-3426

PROVIDER NUMBER
000001988A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,049,214.82	ADJUSTMENTS	173,387.22
COVERED CHARGES	17,005,853.86	CONTRACTUAL ALLOW	10,636,979.72
NON-COVERD CHARGES	43,360.96	TOTAL MEDICAID LIAB	6,368,874.14
		LESS: COB	5,005.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,363,868.23

TOTAL NUMBER OF ADMISSIONS 1,334

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,413		6	9,654,911.00		7,047.00
ROUTINE NURSERY	55		0	40,040.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,468		6	9,694,951.00		7,047.00
SPECIAL CARE SERVICES						
CCU	240		0	440,084.50		0.00
ICU	87		0	246,558.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	327		0	686,642.50		0.00
TOTAL ACCOMODATIONS	8,795		6	10,381,593.50		7,047.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,609,957.88	0.00	OTHER LAB	19,685.00	0.00
MED/SURG SUPPLY	214,457.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,598,560.81	0.00	EDUCATION & TRAINING	4,455.00	0.00
RADIOLOGY-DIAGNOSTIC	84,898.00	320.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	283,510.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,017.67	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	71,232.00	0.00	MRI SERVICES	43,376.00	0.00
IV THERAPY	221,341.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	167,089.92	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	56,719.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	339,146.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,410.00	0.00	AMBULANCE	0.00	35,993.00
GI SERVICES	20,784.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	677,698.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,034.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	14,478.96	0.00	INJECTABLE DRUGS	277,829.75	0.00
RADIOLOGY THERAPEUTIC	36,540.19	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	685.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,700.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	15,456.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,740.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,580.00	0.00	IMPL DEV CHARGE PATIENTS	87,136.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,723.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	49,020.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	68,126.00	0.00			
AUDIOLOGY	2,170.00	0.00			
CARDIOLOGY	414,723.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,979.60	0.00			
			TOTAL ANCILLARY	6,624,260.36	36,313.96
			TOTAL ACCOMODATIONS	10,381,593.50	7,047.00
			TOTAL CHARGES	17,005,853.86	43,360.96

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

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

Run Date: 08/28/2018
 Run Time: 23:40:53
 Page: 3

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,575.89	ADJUSTMENTS	0.00
COVERED CHARGES	55,575.89	CONTRACTUAL ALLOW	20,110.19
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	35,465.70
		LESS: COB	35,465.70
		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	11,518.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	11,518.00		0.00
SPECIAL CARE SERVICES						
CCU	1		0	1,837.50		0.00
ICU	1		0	2,834.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	4,671.50		0.00
TOTAL ACCOMODATIONS	12		0	16,189.50		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,199.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,319.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,628.00	0.00	EDUCATION & TRAINING	45.00	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	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,687.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,940.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,324.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,446.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	405.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,095.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	39,386.39	0.00
			TOTAL ACCOMODATIONS	16,189.50	0.00
			TOTAL CHARGES	55,575.89	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: 08/28/2018
Run Time: 23:40:54
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,796,047.34	ADJUSTMENTS	247,032.13
COVERED CHARGES	9,353,790.81	CONTRACTUAL ALLOW	7,287,175.11
NON-COVERD CHARGES	442,256.53	TOTAL MEDICAID LIAB	2,066,615.70
		LESS: COB	4,315.05
		LESS: COPAYMENT	4,734.00
		REIMBURSEMENT	2,057,566.65
		ALL OTHER	1,896,850.54
		FEE SCHEDULE-LAB	100,171.13
		INJECTABLE DRUGS	60,544.98

TOTAL NUMBER OF CLAIMS 3,381

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	279,111.03	309.00	OTHER LAB	74,266.00	0.00
MED/SURG SUPPLY	68,193.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,730.00
RADIOLOGY-DIAGNOSTIC	379,764.42	13,969.36	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,144,241.00	83,198.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,690.00	8,515.00	FEE SCHEDULE LAB	1,115,559.82	19,361.13
EKG/ECG	108,050.00	4,237.00	MRI SERVICES	375,617.00	12,944.00
IV THERAPY	673,827.25	14,470.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	408,582.82	22,259.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,045.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	96,376.00	2,600.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	118,627.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	191,505.50	15,051.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,930,481.20	4,689.54	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,305.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	332,111.85	141,782.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	994.00	1,988.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,500.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,072,724.00	4,340.00	IMPL DEV CHARGE PATIENTS	14,689.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	372.00
OTHER IMAGING SERVICE	179,994.25	16,251.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	21,844.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	143,644.00	15,655.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	301,643.61	27,686.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	69,126.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	228,776.87	27,348.40			
			TOTAL ANCILLARY	9,353,790.81	442,256.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,353,790.81	442,256.53

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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017117080344	04/10/17 - 04/10/17	05/01/17	0.00	372.00	0.00	0.00	0.00
TOTAL				0.00	372.00	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: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	282,106.60	ADJUSTMENTS	0.00
COVERED CHARGES	141,445.86	CONTRACTUAL ALLOW	-27,520.07
NON-COVERD CHARGES	140,660.74	TOTAL MEDICAID LIAB	168,965.93
		LESS: COB	168,890.93
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,492.54	203.48	OTHER LAB	2,418.00	0.00
MED/SURG SUPPLY	793.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,410.00	618.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,423.00	10,019.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,838.00	572.00
EKG/ECG	510.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,850.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,900.00	13,416.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,120.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,778.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,200.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	940.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	813.00	99,597.44
RADIOLOGY THERAPEUTIC	5,075.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	9,672.00	372.00	IMPL DEV CHARGE PATIENTS	0.00	2,445.82
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,170.00	3,474.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,475.00	824.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	816.00	3,341.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,530.28	0.00			
			TOTAL ANCILLARY	141,445.86	140,660.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	141,445.86	140,660.74

Report : CLM-0808-0
Process : CLMJ0800
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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	574,909.74	ADJUSTMENTS	382.58
COVERED CHARGES	560,325.53	CONTRACTUAL ALLOW	540,522.77
NON-COVERD CHARGES	14,584.21	TOTAL MEDICAID LIAB	19,802.76
		LESS: COB	26.32
		LESS: COPAYMENT	572.65
		REIMBURSEMENT	19,203.79
		TOTAL NUMBER OF CLAIMS	354

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,249.42	121.07	OTHER LAB	2,943.00	0.00
MED/SURG SUPPLY	731.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,792.96	1,604.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,387.00	10,523.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	555.00	FEE SCHEDULE LAB	93,765.00	1,078.00
EKG/ECG	6,107.00	0.00	MRI SERVICES	3,236.00	0.00
IV THERAPY	40,603.50	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	3,600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	258,815.46	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,728.19	702.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,200.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,166.72	0.00			
			TOTAL ANCILLARY	560,325.53	14,584.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	560,325.53	14,584.21

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

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

Run Date: 08/28/2018
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,667.68	ADJUSTMENTS	0.00
COVERED CHARGES	8,830.68	CONTRACTUAL ALLOW	4,463.40
NON-COVERD CHARGES	837.00	TOTAL MEDICAID LIAB	4,367.28
		LESS: COB	4,355.28
		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: 08/28/2018
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER VILLA RICA
 601 DALLAS HWY
 VILLA RICA,GA 30180-1202

PROVIDER NUMBER
 000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.48	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	756.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,633.00	107.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	134.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,535.20	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	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	450.00	730.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,830.68	837.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,830.68	837.00

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

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,899,151.39	ADJUSTMENTS	103,523.82
COVERED CHARGES	1,842,863.33	CONTRACTUAL ALLOW	1,140,815.55
NON-COVERD CHARGES	56,288.06	TOTAL MEDICAID LIAB	702,047.78
		LESS: COB	2,465.21
		LESS: COPAYMENT	498.00
		REIMBURSEMENT	699,084.57

TOTAL NUMBER OF CLAIMS 122

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,628.48	150.00	OTHER LAB	1,904.00	0.00
MED/SURG SUPPLY	32,435.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	180.00
RADIOLOGY-DIAGNOSTIC	4,079.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,526.00	9,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	555.00	FEE SCHEDULE LAB	44,180.63	1,512.00
EKG/ECG	5,980.00	482.00	MRI SERVICES	0.00	0.00
IV THERAPY	161,547.75	7,019.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	125,547.00	15,835.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,565.00	600.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,630.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,589.00	2,639.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,971.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,965.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,168,621.10	892.87
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	280.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	61,961.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,893.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	872.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	9,570.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	86,944.00	5,385.00			
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	36,101.04	195.19			
			TOTAL ANCILLARY	1,842,863.33	56,288.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,842,863.33	56,288.06

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,122.54	ADJUSTMENTS	0.00
COVERED CHARGES	50,122.54	CONTRACTUAL ALLOW	14,993.89
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	35,128.65
		LESS: COB	35,128.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

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

Run Date: 08/28/2018
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA
601 DALLAS HWY
VILLA RICA,GA 30180-1202

PROVIDER NUMBER
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	49,225.44	0.00
RADIOLOGY THERAPEUTIC	885.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	50,122.54	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,122.54	0.00

** END OF REPORT **

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

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

Run Date: 08/28/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER 000002065A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,854,251.18	ADJUSTMENTS	1,294,749.96
COVERED CHARGES	13,784,203.61	CONTRACTUAL ALLOW	8,598,241.12
NON-COVERD CHARGES	70,047.57	TOTAL MEDICAID LIAB	5,185,962.49
		LESS: COB	67,693.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,118,268.77

TOTAL NUMBER OF ADMISSIONS 597

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	928		0	867,680.00		38,060.00
ROUTINE NURSERY	129		0	83,420.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,057		0	951,100.00		38,060.00
SPECIAL CARE SERVICES						
CCU	1,054		0	1,709,610.00		0.00
ICU	311		0	675,119.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,365		0	2,384,729.00		0.00
TOTAL ACCOMODATIONS	2,422		0	3,335,829.00		38,060.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,544,164.47	0.00	OTHER LAB	59,802.30	0.00
MED/SURG SUPPLY	573,681.59	3,778.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,845,628.90	0.00	EDUCATION & TRAINING	6,358.90	0.00
RADIOLOGY-DIAGNOSTIC	235,654.25	0.00	OTHER THERAPEUTIC SVC	0.00	473.20
CT SCAN	673,898.70	927.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	103,005.30	0.16	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	204,290.75	0.00	MRI SERVICES	77,100.00	0.00
IV THERAPY	2,361.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,474,256.05	6,519.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	230,470.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	536,156.05	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	378,667.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	91,075.55	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	870,585.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	116,178.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	82,754.40	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	32,759.65	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,995.40	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,044.10	0.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	75,819.60	709.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,378.65	807.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	281,394.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	93,004.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	214,849.00	15,431.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	80,669.15	3,340.20			
AUDIOLOGY	6,429.00	0.00			
CARDIOLOGY	521,401.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,509.55	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,028.80	0.00			
			TOTAL ANCILLARY	10,448,374.61	31,987.57
			TOTAL ACCOMODATIONS	3,335,829.00	38,060.00
			TOTAL CHARGES	13,784,203.61	70,047.57

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 WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	133,727.15	ADJUSTMENTS	0.00
COVERED CHARGES	130,191.95	CONTRACTUAL ALLOW	45,533.14
NON-COVERD CHARGES	3,535.20	TOTAL MEDICAID LIAB	84,658.81
		LESS: COB	84,658.81
		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	31		0	28,985.00		1,430.00
ROUTINE NURSERY	2		0	1,020.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	33		0	30,005.00		1,430.00
SPECIAL CARE SERVICES						
CCU	3		0	4,560.00		0.00
ICU	2		0	4,400.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	8,960.00		0.00
TOTAL ACCOMODATIONS	38		0	38,965.00		1,430.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,011.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,962.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,046.35	0.00	EDUCATION & TRAINING	38.20	0.00
RADIOLOGY-DIAGNOSTIC	873.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,200.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	949.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	687.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,026.90	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,067.45	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	200.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,176.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,779.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,999.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,995.90	0.00	INJECTABLE DRUGS	239.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	280.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,149.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,730.10	2,105.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	150.00	0.00			
CARDIOLOGY	1,663.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	91,226.95	2,105.20
			TOTAL ACCOMODATIONS	38,965.00	1,430.00
			TOTAL CHARGES	130,191.95	3,535.20

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,532,778.13	ADJUSTMENTS	433,261.19
COVERED CHARGES	12,987,810.84	CONTRACTUAL ALLOW	10,379,071.40
NON-COVERD CHARGES	1,544,967.29	TOTAL MEDICAID LIAB	2,608,739.44
		LESS: COB	10,794.94
		LESS: COPAYMENT	5,022.30
		REIMBURSEMENT	2,592,922.20
		ALL OTHER	2,207,461.75
		FEE SCHEDULE-LAB	240,429.34
		INJECTABLE DRUGS	145,031.11

TOTAL NUMBER OF CLAIMS 6,554

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	276,666.19	85.00	OTHER LAB	220,628.90	0.00
MED/SURG SUPPLY	291,361.57	91,334.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	126.30	EDUCATION & TRAINING	0.00	971.20
RADIOLOGY-DIAGNOSTIC	460,623.85	43,919.35	OTHER THERAPEUTIC SVC	0.00	1,069.20
CT SCAN	894,942.20	163,469.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,465.20	2,290.74	FEE SCHEDULE LAB	2,367,255.96	143,727.11
EKG/ECG	265,684.45	31,968.75	MRI SERVICES	86,255.00	17,510.00
IV THERAPY	316,916.25	28,258.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,114,162.10	104,075.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,196.95	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	131,441.30	21,799.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	429,994.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	278,516.36	51,091.39	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,510,579.55	117,872.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	195,309.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	348,148.31	159,994.59
RADIOLOGY THERAPEUTIC	244,943.40	367,283.80	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	605.70	0.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	227.90	885.83	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,504.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,313.50	3,276.75	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	369,309.45	46,882.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,366.20	1,052.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	157,324.30	61,846.80			
AUDIOLOGY	1,046.40	1,669.10			
CARDIOLOGY	507,499.15	66,859.65			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,614.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	430,412.55	14,142.50			
			TOTAL ANCILLARY	12,987,810.84	1,544,967.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,987,810.84	1,544,967.29

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 WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	237,525.50	ADJUSTMENTS	0.00
COVERED CHARGES	193,168.50	CONTRACTUAL ALLOW	67,020.99
NON-COVERD CHARGES	44,357.00	TOTAL MEDICAID LIAB	126,147.51
		LESS: COB	126,111.51
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 87

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,064.58	0.00	OTHER LAB	696.20	0.00
MED/SURG SUPPLY	2,996.85	104.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,464.20	592.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,063.00	5,920.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,718.90	1,286.20
EKG/ECG	2,062.50	0.00	MRI SERVICES	0.00	6,890.00
IV THERAPY	10,134.30	98.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,400.05	3,418.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,919.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	200.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,347.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,556.15	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,828.90	723.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,014.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,813.32	8,843.45
RADIOLOGY THERAPEUTIC	2,380.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	74.20	273.50	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	1,298.80	12,187.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,258.60	92.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,476.75	1,370.50			
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	2,954.50	0.00			
			TOTAL ANCILLARY	193,168.50	44,357.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	193,168.50	44,357.00

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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WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,025,190.17	ADJUSTMENTS	700.22
COVERED CHARGES	992,439.91	CONTRACTUAL ALLOW	950,037.39
NON-COVERD CHARGES	32,750.26	TOTAL MEDICAID LIAB	42,402.52
		LESS: COB	0.00
		LESS: COPAYMENT	1,318.74
		REIMBURSEMENT	41,083.78
		TOTAL NUMBER OF CLAIMS	758

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,395.50	0.00	OTHER LAB	3,010.15	0.00
MED/SURG SUPPLY	1,945.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,590.67	1,372.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,720.00	13,748.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	167,034.40	3,911.30
EKG/ECG	17,187.50	1,031.25	MRI SERVICES	2,120.00	0.00
IV THERAPY	553.60	263.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	582.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,611.70	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	643,567.39	5,231.71	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,509.25	80.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,747.55	6,929.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,448.40	183.30			
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	415.60	0.00			
			TOTAL ANCILLARY	992,439.91	32,750.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	992,439.91	32,750.26

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 WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,725.65	ADJUSTMENTS	0.00
COVERED CHARGES	19,020.20	CONTRACTUAL ALLOW	8,446.14
NON-COVERD CHARGES	705.45	TOTAL MEDICAID LIAB	10,574.06
		LESS: COB	10,559.06
		LESS: COPAYMENT	15.00
		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

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	269.00	0.00	OTHER LAB	696.20	0.00
MED/SURG SUPPLY	95.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,249.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,909.80	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	189.45	189.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,536.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	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	19,020.20	705.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,020.20	705.45

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

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WEST GEORGIA MEDICAL CENTER
1514 VERNON RD
LAGRANGE,GA 30240-4131

PROVIDER NUMBER
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,887,599.88	ADJUSTMENTS	173,166.28
COVERED CHARGES	1,570,928.89	CONTRACTUAL ALLOW	1,237,873.50
NON-COVERD CHARGES	316,670.99	TOTAL MEDICAID LIAB	333,055.39
		LESS: COB	4,361.67
		LESS: COPAYMENT	483.00
		REIMBURSEMENT	328,210.72

TOTAL NUMBER OF CLAIMS 60

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

WELLSTAR WEST GEORGIA MEDICAL CENTER
 1514 VERNON RD
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,426.32	0.00	OTHER LAB	656.75	0.00
MED/SURG SUPPLY	122,468.80	124,198.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	227.00
RADIOLOGY-DIAGNOSTIC	11,697.40	16,290.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,055.00	6,775.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	445.30	FEE SCHEDULE LAB	40,438.25	1,648.60
EKG/ECG	1,375.00	4,812.50	MRI SERVICES	9,920.00	7,800.00
IV THERAPY	112,474.40	6,352.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	405,594.94	21,287.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,002.05	2,048.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,793.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,404.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,869.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	473,370.23	7,480.28
RADIOLOGY THERAPEUTIC	173,903.05	89,154.30	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,384.10	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,237.15	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,412.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,514.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	81,623.60	23,636.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,822.40	0.00			
			TOTAL ANCILLARY	1,570,928.89	316,670.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,570,928.89	316,670.99

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

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

Run Date: 08/28/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,172.70	ADJUSTMENTS	0.00
COVERED CHARGES	28,172.70	CONTRACTUAL ALLOW	10,881.07
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	17,291.63
		LESS: COB	17,291.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	542.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,983.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	468.60	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,284.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,937.80	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	860.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	95.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,172.70	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,172.70	0.00

** END OF REPORT **

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

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

Run Date: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,229,360.53	ADJUSTMENTS	279,047.19
COVERED CHARGES	10,175,809.20	CONTRACTUAL ALLOW	6,821,423.62
NON-COVERD CHARGES	53,551.33	TOTAL MEDICAID LIAB	3,354,385.58
		LESS: COB	35,167.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,319,218.47

TOTAL NUMBER OF ADMISSIONS 396

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,277		0	728,690.00		41,672.00
ROUTINE NURSERY	117		0	60,750.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,394		0	789,440.00		41,672.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	175		0	237,127.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	175		0	237,127.00		0.00
TOTAL ACCOMODATIONS	1,569		0	1,026,567.00		41,672.00

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

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

Run Date: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,057,413.98	0.00	OTHER LAB	28,695.48	0.00
MED/SURG SUPPLY	822,014.92	304.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	998,433.21	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	175,059.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	458,966.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	144,657.91	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	38,110.00	0.00	MRI SERVICES	86,590.05	0.00
IV THERAPY	46,811.00	0.00	PROFESSIONAL FEES	0.00	648.00
OPERATING ROOM	811,929.74	626.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	83,801.52	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	411,653.63	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	261,348.17	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	462,306.81	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	221,076.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	48,315.98	0.00	INJECTABLE DRUGS	1,426,311.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	37,852.52	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,669.30	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	1,182.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,123,224.60	818.85
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,107.65
OTHER IMAGING SERVICE	36,365.98	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	103,889.67	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,518.00	0.00			
AUDIOLOGY	21,000.00	0.00			
CARDIOLOGY	116,462.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,906.67	192.00			
			TOTAL ANCILLARY	9,149,242.20	11,879.33
			TOTAL ACCOMODATIONS	1,026,567.00	41,672.00
			TOTAL CHARGES	10,175,809.20	53,551.33

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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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016256034222	08/27/16 - 09/01/16	09/19/16	0.00	2,533.65	0.00	0.00	0.00
615	2016327005314	11/02/16 - 11/09/16	11/28/16	0.00	2,787.00	0.00	0.00	0.00
615	2017166123420	02/06/17 - 02/21/17	06/19/17	0.00	2,787.00	0.00	0.00	0.00
TOTAL				0.00	8,107.65	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

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,769.56	ADJUSTMENTS	0.00
COVERED CHARGES	85,741.56	CONTRACTUAL ALLOW	20,161.86
NON-COVERD CHARGES	28.00	TOTAL MEDICAID LIAB	65,579.70
		LESS: COB	65,579.70
		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	1,138.00		28.00
ROUTINE NURSERY	0		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	1,138.00		28.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	6,744.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	6,744.00		0.00
TOTAL ACCOMODATIONS	7		0	7,882.00		28.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,702.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,332.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,911.59	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,324.21	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	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,242.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,814.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,680.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,645.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,834.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,875.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	312.50	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	186.00	0.00			
			TOTAL ANCILLARY	77,859.56	0.00
			TOTAL ACCOMODATIONS	7,882.00	28.00
			TOTAL CHARGES	85,741.56	28.00

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: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,531,710.94	ADJUSTMENTS	299,389.73
COVERED CHARGES	9,035,264.36	CONTRACTUAL ALLOW	6,938,461.75
NON-COVERD CHARGES	496,446.58	TOTAL MEDICAID LIAB	2,096,802.61
		LESS: COB	1,626.70
		LESS: COPAYMENT	4,359.26
		REIMBURSEMENT	2,090,816.65
		ALL OTHER	1,731,119.52
		FEE SCHEDULE-LAB	126,209.38
		INJECTABLE DRUGS	233,487.75

TOTAL NUMBER OF CLAIMS 3,705

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	388,341.25	702.65	OTHER LAB	46,956.02	0.00
MED/SURG SUPPLY	358,313.72	185.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	38.85
RADIOLOGY-DIAGNOSTIC	338,513.48	21,515.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,076,562.30	76,346.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,159.87	11,616.02	FEE SCHEDULE LAB	695,800.50	38,168.33
EKG/ECG	62,160.72	4,738.00	MRI SERVICES	272,669.85	14,953.00
IV THERAPY	272,918.00	26,134.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	723,016.55	62,948.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,601.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,915.31	10,815.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	218,388.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,525,813.75	14,464.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	394,959.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,793,511.48	147,758.69
RADIOLOGY THERAPEUTIC	112,352.31	165.18	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,072.84	641.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,940.30	2,876.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,596.00	680.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	107,976.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,067.30
OTHER IMAGING SERVICE	148,499.10	20,326.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,132.90	1,992.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	76,043.90	17,598.90			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	111,714.50	10,795.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	87,547.56	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	114,787.20	5,919.50			
			TOTAL ANCILLARY	9,035,264.36	496,446.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,035,264.36	496,446.58

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

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

Run Date: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916256000226	08/29/16 - 08/29/16	09/19/16	0.00	2,533.65	0.00	0.00	0.00
615	2016279002518	09/12/16 - 09/12/16	10/10/16	0.00	2,533.65	0.00	0.00	0.00
TOTAL				0.00	5,067.30	0.00	0.00	0.00

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

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

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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,103.73	ADJUSTMENTS	0.00
COVERED CHARGES	95,324.56	CONTRACTUAL ALLOW	32,809.72
NON-COVERD CHARGES	39,779.17	TOTAL MEDICAID LIAB	62,514.84
		LESS: COB	62,496.62
		LESS: COPAYMENT	18.22
		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

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,172.42	1,527.19	OTHER LAB	2,409.00	0.00
MED/SURG SUPPLY	4,951.17	628.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,428.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,893.00	18,435.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,582.66	279.00
EKG/ECG	206.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,984.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,747.00	13,933.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,413.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,942.53	264.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,130.13	442.62
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	45.54	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,460.00	1,424.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,210.00	2,845.50			
			TOTAL ANCILLARY	95,324.56	39,779.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	95,324.56	39,779.17

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

Run Date: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,873.19	ADJUSTMENTS	217.76
COVERED CHARGES	117,431.43	CONTRACTUAL ALLOW	110,886.45
NON-COVERD CHARGES	3,441.76	TOTAL MEDICAID LIAB	6,544.98
		LESS: COB	0.00
		LESS: COPAYMENT	179.47
		REIMBURSEMENT	6,365.51
		TOTAL NUMBER OF CLAIMS	117

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,948.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,061.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,762.90	278.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,859.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,874.41	334.00
EKG/ECG	1,442.00	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	469.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	168.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	100.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,585.37	528.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,757.64	1,507.76
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	1,295.00	732.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	108.00	62.00			
			TOTAL ANCILLARY	117,431.43	3,441.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	117,431.43	3,441.76

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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,178.99	ADJUSTMENTS	0.00
COVERED CHARGES	1,158.99	CONTRACTUAL ALLOW	382.57
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	776.42
		LESS: COB	773.42
		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

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	110.00	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,158.99	20.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,158.99	20.00

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

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

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

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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,198,752.99	ADJUSTMENTS	63,248.39
COVERED CHARGES	2,962,617.75	CONTRACTUAL ALLOW	2,433,204.67
NON-COVERD CHARGES	236,135.24	TOTAL MEDICAID LIAB	529,413.08
		LESS: COB	0.00
		LESS: COPAYMENT	381.00
		REIMBURSEMENT	529,032.08
		TOTAL NUMBER OF CLAIMS	92

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,626.04	594.95	OTHER LAB	850.00	0.00
MED/SURG SUPPLY	107,227.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,259.05	2,442.07	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,070.00	4,535.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	194.00	671.02	FEE SCHEDULE LAB	23,345.66	402.00
EKG/ECG	824.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	62,081.00	27,498.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	132,658.00	332.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	466.00	650.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,463.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,873.00	731.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,975.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,238,708.78	197,397.66
RADIOLOGY THERAPEUTIC	94,365.77	495.54	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	278.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	984.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	94,108.68	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	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	25,457.74	108.00			
			TOTAL ANCILLARY	2,962,617.75	236,135.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,962,617.75	236,135.24

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: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,477.46	ADJUSTMENTS	0.00
COVERED CHARGES	67,324.22	CONTRACTUAL ALLOW	19,173.65
NON-COVERD CHARGES	1,153.24	TOTAL MEDICAID LIAB	48,150.57
		LESS: COB	48,138.57
		LESS: COPAYMENT	12.00
		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: 08/29/2018
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	979.43	211.64	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	316.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	334.00	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,568.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	58,949.42	921.60
RADIOLOGY THERAPEUTIC	4,068.41	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	108.00	0.00			
			TOTAL ANCILLARY	67,324.22	1,153.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,324.22	1,153.24

** 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: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,295,667.37	ADJUSTMENTS	28,718.27
COVERED CHARGES	2,204,397.24	CONTRACTUAL ALLOW	1,101,715.47
NON-COVERD CHARGES	91,270.13	TOTAL MEDICAID LIAB	1,102,681.77
		LESS: COB	11,968.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,090,713.16

TOTAL NUMBER OF ADMISSIONS 203

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,257		0	625,686.00		73,948.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,257		0	625,686.00		73,948.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	57		0	65,241.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	65,241.00		0.00
TOTAL ACCOMODATIONS	1,314		0	690,927.00		73,948.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,399.77	0.00	OTHER LAB	3,710.00	0.00
MED/SURG SUPPLY	52,258.96	130.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	448,470.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,802.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,774.00	1,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,086.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	29,915.00	310.00	MRI SERVICES	16,202.00	0.00
IV THERAPY	149,184.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,400.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,272.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,659.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,920.00	1,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,556.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,645.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	420,002.21	2,812.99
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,367.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,232.06	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,545.19	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,880.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,246.00	11,169.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,237.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,707.00	0.00			
			TOTAL ANCILLARY	1,513,470.24	17,322.13
			TOTAL ACCOMODATIONS	690,927.00	73,948.00
			TOTAL CHARGES	2,204,397.24	91,270.13

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/16 THROUGH 08/31/17
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: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,725,849.01	ADJUSTMENTS	123,218.23
COVERED CHARGES	1,607,854.70	CONTRACTUAL ALLOW	1,210,447.91
NON-COVERD CHARGES	117,994.31	TOTAL MEDICAID LIAB	397,406.79
		LESS: COB	311.57
		LESS: COPAYMENT	1,128.00
		REIMBURSEMENT	395,967.22
		ALL OTHER	332,855.97
		FEE SCHEDULE-LAB	49,494.25
		INJECTABLE DRUGS	13,617.00
		TOTAL NUMBER OF CLAIMS	1,362

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

PROVIDER NUMBER
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,351.58	79.68	OTHER LAB	8,466.00	0.00
MED/SURG SUPPLY	60,643.64	381.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,285.00	1,570.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	244,355.00	45,125.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,199.00	0.00	FEE SCHEDULE LAB	455,398.00	20,401.00
EKG/ECG	24,855.00	0.00	MRI SERVICES	56,871.00	4,752.00
IV THERAPY	135,584.00	2,293.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,501.50	6,050.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,749.00	10,004.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,557.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,490.00	1,730.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	204,844.00	399.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,752.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,412.98	11,372.28
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	359.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	444.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	750.00	2,645.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,856.00	940.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,273.00	3,000.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,592.00	6,034.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,719.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,350.00	414.00			
			TOTAL ANCILLARY	1,607,854.70	117,994.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,607,854.70	117,994.31

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

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

PROVIDER NUMBER
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,542.78	ADJUSTMENTS	0.00
COVERED CHARGES	8,567.67	CONTRACTUAL ALLOW	4,317.56
NON-COVERD CHARGES	3,975.11	TOTAL MEDICAID LIAB	4,250.11
		LESS: COB	4,247.11
		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

APPLING HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 163 E TOLLISON ST 000000052A SERVICE DATES 09/01/16 THROUGH 08/31/17
 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	5.19	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.44	57.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,069.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,730.00	3,655.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,423.00	263.00
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	3,066.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52.04	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,567.67	3,975.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,567.67	3,975.11

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

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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,277.50	ADJUSTMENTS	426.52
COVERED CHARGES	71,800.34	CONTRACTUAL ALLOW	65,535.06
NON-COVERD CHARGES	2,477.16	TOTAL MEDICAID LIAB	6,265.28
		LESS: COB	0.00
		LESS: COPAYMENT	186.30
		REIMBURSEMENT	6,078.98
		TOTAL NUMBER OF CLAIMS	112

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	756.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	578.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,556.00	311.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,460.00	1,135.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,744.00	944.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,094.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,950.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	661.16	87.16
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
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	71,800.34	2,477.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	71,800.34	2,477.16

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

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

PROVIDER NUMBER
000000052A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,289.19	ADJUSTMENTS	0.00
COVERED CHARGES	2,257.19	CONTRACTUAL ALLOW	1,503.64
NON-COVERD CHARGES	32.00	TOTAL MEDICAID LIAB	753.55
		LESS: COB	753.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	326.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	780.00	32.00
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	972.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36.50	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	2,257.19	32.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,257.19	32.00

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	09/01/16	THROUGH	08/31/17
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: 08/29/2018
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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	09/01/16	THROUGH	08/31/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,452,251.65	ADJUSTMENTS	798,641.28
COVERED CHARGES	30,927,056.65	CONTRACTUAL ALLOW	20,509,212.95
NON-COVERD CHARGES	1,525,195.00	TOTAL MEDICAID LIAB	10,417,843.70
		LESS: COB	94,259.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,323,584.29

TOTAL NUMBER OF ADMISSIONS 1,111

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,153		0	3,798,079.00		1,218,861.00
ROUTINE NURSERY	78		0	44,955.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,231		0	3,843,034.00		1,218,861.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,037		0	1,451,568.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK 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		32,012.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,037		38	1,451,568.00		32,012.00
TOTAL ACCOMODATIONS	7,268		38	5,294,602.00		1,250,873.00

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,503,684.60	0.00	OTHER LAB	55,628.00	0.00
MED/SURG SUPPLY	2,220,833.36	15.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,118,854.79	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	553,465.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,273,753.00	7,282.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	397,610.73	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	114,934.00	0.00	MRI SERVICES	251,794.00	0.00
IV THERAPY	6,248.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,903,418.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	111,542.00	97.00	REHAB THERAPY	486.00	0.00
RESPIRATORY SERVICES	1,573,696.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	134,614.00	12,420.00	AMBULANCE	0.00	0.00
GI SERVICES	99,688.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,081,416.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	175,671.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	130,460.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	186,102.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	216,242.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	76,368.72	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	205,296.00	18,786.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	10,712.00	TRAUMA RESPONSE	0.00	6,087.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,852,415.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	103,689.00	10,470.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	226,342.00	208,453.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	131,755.00	0.00			
AUDIOLOGY	15,300.00	0.00			
CARDIOLOGY	825,838.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	21,250.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	64,060.00	0.00			
			TOTAL ANCILLARY	25,632,454.65	274,322.00
			TOTAL ACCOMODATIONS	5,294,602.00	1,250,873.00
			TOTAL CHARGES	30,927,056.65	1,525,195.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,740.00	ADJUSTMENTS	0.00
COVERED CHARGES	34,025.00	CONTRACTUAL ALLOW	6,989.07
NON-COVERD CHARGES	1,715.00	TOTAL MEDICAID LIAB	27,035.93
		LESS: COB	27,035.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	4,263.00		1,699.00
ROUTINE NURSERY	2		0	1,024.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	5,287.00		1,699.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	4,916.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	4,916.00		0.00
TOTAL ACCOMODATIONS	13		0	10,203.00		1,699.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,999.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,119.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,960.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,644.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	177.00	0.00	MRI SERVICES	1,431.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	301.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	319.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,734.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	536.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	55.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	425.00	0.00			
CARDIOLOGY	1,735.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	203.00	16.00			
			TOTAL ANCILLARY	23,822.00	16.00
			TOTAL ACCOMODATIONS	10,203.00	1,699.00
			TOTAL CHARGES	34,025.00	1,715.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,817,419.95	ADJUSTMENTS	439,155.34
COVERED CHARGES	18,121,766.64	CONTRACTUAL ALLOW	14,482,588.14
NON-COVERD CHARGES	1,695,653.31	TOTAL MEDICAID LIAB	3,639,178.50
		LESS: COB	6,501.57
		LESS: COPAYMENT	15,914.83
		REIMBURSEMENT	3,616,762.10
		ALL OTHER	2,536,452.98
		FEE SCHEDULE-LAB	286,555.67
		INJECTABLE DRUGS	793,753.45

TOTAL NUMBER OF CLAIMS 8,885

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	294,635.20	15,052.13	OTHER LAB	108,180.00	0.00
MED/SURG SUPPLY	744,293.00	172.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	560,591.00	17,136.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,782,813.00	225,201.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	88,178.00	74,258.17	FEE SCHEDULE LAB	2,161,920.70	127,745.00
EKG/ECG	122,217.00	177.00	MRI SERVICES	387,730.00	17,822.00
IV THERAPY	1,066,014.00	132,506.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	956,104.32	172,540.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,621.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151,408.00	32,695.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	121,912.00	15,314.00	AMBULANCE	0.00	0.00
GI SERVICES	298,776.04	63,441.96	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,230,425.20	1,488.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	196,116.00	4,216.00	DRUG-SPECIFIC/HOME IV	0.00	3,300.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,915,957.18	469,341.51
RADIOLOGY THERAPEUTIC	1,758,796.00	7,914.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,500.00	33,826.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,375.00	5,665.06	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	184,686.00	8,771.00	TRAUMA RESPONSE	0.00	7,952.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	183,297.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	452,061.00	41,475.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,252.00	14,580.00			
ONCOLOGY	4,403.00	1,258.00			
NUCLEAR MEDICINE	324,122.00	40,055.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	364,823.00	119,618.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	142,834.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	415,726.00	42,132.00			
			TOTAL ANCILLARY	18,121,766.64	1,695,653.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,121,766.64	1,695,653.31

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	181,148.50	ADJUSTMENTS	0.00
COVERED CHARGES	132,124.50	CONTRACTUAL ALLOW	34,280.81
NON-COVERD CHARGES	49,024.00	TOTAL MEDICAID LIAB	97,843.69
		LESS: COB	97,744.12
		LESS: COPAYMENT	99.57
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,641.00	0.00	OTHER LAB	256.00	0.00
MED/SURG SUPPLY	5,615.00	1,494.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	125.00	0.00
RADIOLOGY-DIAGNOSTIC	9,710.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,291.00	12,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,291.00	814.00
EKG/ECG	1,482.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,441.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	21,228.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,675.00	202.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	580.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,798.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,914.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,478.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,746.50	1,447.00
RADIOLOGY THERAPEUTIC	2,687.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,719.00	55.00	TRAUMA RESPONSE	0.00	994.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	894.00	179.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,662.00	7,787.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	638.00	1,735.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,620.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,861.00	339.00			
			TOTAL ANCILLARY	132,124.50	49,024.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	132,124.50	49,024.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	286,559.03	ADJUSTMENTS	105.88
COVERED CHARGES	270,697.64	CONTRACTUAL ALLOW	255,649.78
NON-COVERD CHARGES	15,861.39	TOTAL MEDICAID LIAB	15,047.86
		LESS: COB	0.00
		LESS: COPAYMENT	399.41
		REIMBURSEMENT	14,648.45
		TOTAL NUMBER OF CLAIMS	269

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	392.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,915.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,606.00	1,463.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,620.00	8,498.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67,470.00	1,389.00
EKG/ECG	3,009.00	0.00	MRI SERVICES	0.00	1,431.00
IV THERAPY	19,890.00	226.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,027.00	475.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,357.00	856.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,194.64	1,024.39
RADIOLOGY THERAPEUTIC	1,283.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	406.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,528.00	499.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	270,697.64	15,861.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	270,697.64	15,861.39

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,758.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,472.00	CONTRACTUAL ALLOW	440.12
NON-COVERD CHARGES	4,286.00	TOTAL MEDICAID LIAB	6,031.88
		LESS: COB	6,028.88
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	261.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	399.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,288.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,310.00	58.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	490.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	100.00	841.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	99.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	343.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,472.00	4,286.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,472.00	4,286.00

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,230,541.55	ADJUSTMENTS	123,092.48
COVERED CHARGES	6,971,983.70	CONTRACTUAL ALLOW	6,195,805.94
NON-COVERD CHARGES	258,557.85	TOTAL MEDICAID LIAB	776,177.76
		LESS: COB	0.00
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	775,709.76
		TOTAL NUMBER OF CLAIMS	139

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,013.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	175,457.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,165.00	4,062.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,237.00	5,348.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,065.04	FEE SCHEDULE LAB	62,968.00	1,608.00
EKG/ECG	5,310.00	0.00	MRI SERVICES	7,538.00	3,574.00
IV THERAPY	120,761.00	339.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	392,923.00	107,366.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,400.00	1,749.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,734.00	4,026.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,020.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,712.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,074,331.20	69,003.81
RADIOLOGY THERAPEUTIC	92,242.00	1,644.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	564.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,206.00	55.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	631,957.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	603.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,248.00	1,728.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,146.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	247,810.00	55,580.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,202.00	846.00			
			TOTAL ANCILLARY	6,971,983.70	258,557.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,971,983.70	258,557.85

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,343.00	ADJUSTMENTS	0.00
COVERED CHARGES	72,605.64	CONTRACTUAL ALLOW	14,005.27
NON-COVERD CHARGES	3,737.36	TOTAL MEDICAID LIAB	58,600.37
		LESS: COB	58,591.37
		LESS: COPAYMENT	9.00
		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
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JOHN D ARCHBOLD MEMORIAL HOSPITAL
 915 GORDON AVE
 THOMASVILLE,GA 31792-6614

PROVIDER NUMBER
 000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	550.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	395.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	275.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,308.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,051.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	582.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,980.64	3,737.36
RADIOLOGY THERAPEUTIC	21,876.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	452.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,136.00	0.00			
			TOTAL ANCILLARY	72,605.64	3,737.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,605.64	3,737.36

** END OF REPORT **

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

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

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS, GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,494,904.82	ADJUSTMENTS	1,391,681.71
COVERED CHARGES	54,689,551.53	CONTRACTUAL ALLOW	40,466,718.34
NON-COVERD CHARGES	805,353.29	TOTAL MEDICAID LIAB	14,222,833.19
		LESS: COB	102,055.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,120,778.06

TOTAL NUMBER OF ADMISSIONS 1,439

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,459		0	7,607,076.00		268,068.00
ROUTINE NURSERY	750		0	1,282,870.00		262,823.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		37.00
TOTAL ROUTINE	6,209		0	8,889,946.00		530,928.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	786		0	2,797,374.00		0.00
NICU	69		0	248,400.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	855		0	3,045,774.00		0.00
TOTAL ACCOMODATIONS	7,064		0	11,935,720.00		530,928.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,792,613.21	0.00	OTHER LAB	223,555.00	0.00
MED/SURG SUPPLY	2,783,536.56	14,441.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,037,691.30	7,762.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	663,607.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,599,661.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	174,518.58	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,858,676.00	0.00	MRI SERVICES	304,853.00	0.00
IV THERAPY	768,079.00	830.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,110,789.00	19,746.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,302,998.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,460,274.00	135.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	198,471.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	388,587.00	1,716.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,419,210.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	258,822.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	420,959.77	0.00	INJECTABLE DRUGS	1,950,266.60	0.00
RADIOLOGY THERAPEUTIC	189,327.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	113,620.09	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	100,484.40	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	517,564.00	40,512.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,611.00	13,468.00	TRAUMA RESPONSE	0.00	86,796.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,598,881.02	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,401.00
OTHER IMAGING SERVICE	286,628.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	465,694.00	60,066.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	159,728.00	15,552.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,293,177.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	79,889.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	221,060.00	0.00			
			TOTAL ANCILLARY	42,753,831.53	274,425.29
			TOTAL ACCOMODATIONS	11,935,720.00	530,928.00
			TOTAL CHARGES	54,689,551.53	805,353.29

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017107017942	03/14/17 - 04/03/17	04/24/17	0.00	1,321.00	0.00	0.00	0.00
615	2017110078561	04/11/17 - 04/14/17	04/24/17	0.00	1,321.00	0.00	0.00	0.00
618	2017202059930	06/27/17 - 07/02/17	07/24/17	0.00	1,512.00	0.00	0.00	0.00
615	2017236075047	06/14/17 - 06/16/17	08/28/17	0.00	1,321.00	0.00	0.00	0.00
615	2217289006264	03/08/17 - 03/29/17	10/23/17	0.00	2,642.00	0.00	0.00	0.00
615	2017291071388	02/05/17 - 03/24/17	10/23/17	0.00	1,321.00	0.00	0.00	0.00
615	2017334072319	04/07/17 - 05/04/17	12/04/17	0.00	1,321.00	0.00	0.00	0.00
615	2018073064049	02/24/17 - 03/12/17	03/19/18	0.00	1,321.00	0.00	0.00	0.00
615	2018213076560	06/09/17 - 06/11/17	08/06/18	0.00	1,321.00	0.00	0.00	0.00
TOTAL				0.00	13,401.00	0.00	0.00	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	129,183.41	ADJUSTMENTS	0.00
COVERED CHARGES	128,333.41	CONTRACTUAL ALLOW	83,001.30
NON-COVERD CHARGES	850.00	TOTAL MEDICAID LIAB	45,332.11
		LESS: COB	45,332.11
		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	12		0	14,176.00		500.00
ROUTINE NURSERY	7		0	9,884.00		350.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	19		0	24,060.00		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	19		0	24,060.00		850.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,756.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,110.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,872.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	572.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,790.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,799.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,705.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,928.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,506.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	888.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,434.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,670.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,080.14	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	3,959.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	32,203.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	104,273.41	0.00
			TOTAL ACCOMODATIONS	24,060.00	850.00
			TOTAL CHARGES	128,333.41	850.00

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: 08/29/2018
Run Time: 00:15:49
Page: 6

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,811,876.88	ADJUSTMENTS	789,801.38
COVERED CHARGES	23,880,543.57	CONTRACTUAL ALLOW	20,168,539.53
NON-COVERD CHARGES	931,333.31	TOTAL MEDICAID LIAB	3,712,004.04
		LESS: COB	31,065.77
		LESS: COPAYMENT	7,918.39
		REIMBURSEMENT	3,673,019.88
		ALL OTHER	3,058,828.55
		FEE SCHEDULE-LAB	425,901.33
		INJECTABLE DRUGS	188,290.00

TOTAL NUMBER OF CLAIMS 8,443

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	470,442.33	0.00	OTHER LAB	178,860.00	855.00
MED/SURG SUPPLY	624,167.63	2,635.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	495.00
RADIOLOGY-DIAGNOSTIC	845,790.00	5,744.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,226,111.00	59,166.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,989.00	12,905.00	FEE SCHEDULE LAB	3,624,727.20	138,718.68
EKG/ECG	336,203.00	3,082.00	MRI SERVICES	525,313.00	34,899.00
IV THERAPY	1,271,030.00	50,963.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,269,039.00	64,652.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	127,021.00	43,000.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	221,207.00	2,949.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,767,779.44	10,175.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	268,791.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,363,824.89	189,067.10
RADIOLOGY THERAPEUTIC	209,333.00	67,222.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,105.00	2,945.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,207.00	1,975.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	92,840.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	86,083.00	11,225.00	TRAUMA RESPONSE	0.00	79,563.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	160,542.47	0.00
LITHOTRIPSY	20,318.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	968,864.00	23,015.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	107,920.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	345,502.00	6,942.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	519,438.00	25,320.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	321,954.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	855,681.61	980.00			
			TOTAL ANCILLARY	23,880,543.57	931,333.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,880,543.57	931,333.31

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 ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	283,452.11	ADJUSTMENTS	0.00
COVERED CHARGES	240,241.19	CONTRACTUAL ALLOW	134,469.50
NON-COVERD CHARGES	43,210.92	TOTAL MEDICAID LIAB	105,771.69
		LESS: COB	105,699.04
		LESS: COPAYMENT	72.65
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 88

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

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC. PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 1199 PRINCE AVE 000000074A SERVICE DATES 10/01/16 THROUGH 06/30/17
 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	9,653.85	0.00	OTHER LAB	1,230.00	0.00
MED/SURG SUPPLY	7,754.17	161.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,604.00	494.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,773.00	4,762.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,826.32	1,314.44
EKG/ECG	1,276.00	0.00	MRI SERVICES	5,662.00	0.00
IV THERAPY	18,423.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,281.00	31,176.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	816.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,383.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,360.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,177.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,103.85	1,772.64
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	600.00	281.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	438.00	1,793.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,387.00	1,456.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,598.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,853.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,042.00	0.00			
			TOTAL ANCILLARY	240,241.19	43,210.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	240,241.19	43,210.92

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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PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	564,236.75	ADJUSTMENTS	379.58
COVERED CHARGES	550,680.77	CONTRACTUAL ALLOW	531,269.59
NON-COVERD CHARGES	13,555.98	TOTAL MEDICAID LIAB	19,411.18
		LESS: COB	0.00
		LESS: COPAYMENT	584.83
		REIMBURSEMENT	18,826.35
		TOTAL NUMBER OF CLAIMS	347

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,562.74	0.00	OTHER LAB	2,085.00	0.00
MED/SURG SUPPLY	1,469.41	323.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,515.00	6,961.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,799.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	86,400.00	2,261.00
EKG/ECG	3,828.00	0.00	MRI SERVICES	2,011.00	2,088.00
IV THERAPY	16,107.00	205.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	410.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,570.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	355,517.00	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	13,997.62	322.30
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	150.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	122.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,137.00	1,395.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	550,680.77	13,555.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	550,680.77	13,555.98

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

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

Run Date: 08/29/2018
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,146.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,050.00	CONTRACTUAL ALLOW	8,987.17
NON-COVERD CHARGES	96.00	TOTAL MEDICAID LIAB	2,062.83
		LESS: COB	2,056.83
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	2,426.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,909.00	96.00
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	5,744.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,050.00	96.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,050.00	96.00

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

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

Run Date: 08/29/2018
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,537,868.56	ADJUSTMENTS	70,628.05
COVERED CHARGES	2,491,930.16	CONTRACTUAL ALLOW	2,099,847.81
NON-COVERD CHARGES	45,938.40	TOTAL MEDICAID LIAB	392,082.35
		LESS: COB	0.00
		LESS: COPAYMENT	738.00
		REIMBURSEMENT	391,344.35

TOTAL NUMBER OF CLAIMS 71

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

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
 1199 PRINCE AVE
 ATHENS,GA 30606-2797

PROVIDER NUMBER
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,904.00	0.00	OTHER LAB	1,958.00	0.00
MED/SURG SUPPLY	124,639.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,217.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,045.00	2,255.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	880.00	FEE SCHEDULE LAB	57,927.00	2,651.00
EKG/ECG	2,871.00	5,526.00	MRI SERVICES	0.00	0.00
IV THERAPY	241,561.00	205.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	122,477.00	1.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,830.00	1,204.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,710.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,523.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,407.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,207,001.68	11,377.40
RADIOLOGY THERAPEUTIC	14,657.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	264.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,300.00	2,075.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	392,470.68	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,374.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,358.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	215,297.00	19,500.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,646.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,756.00	0.00			
			TOTAL ANCILLARY	2,491,930.16	45,938.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,491,930.16	45,938.40

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

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

Run Date: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ATHENS REGIONAL MEDICAL CENTER, INC.
1199 PRINCE AVE
ATHENS,GA 30606-2797

PROVIDER NUMBER
000000074A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000118A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,671,515.45	ADJUSTMENTS	102,005.88
COVERED CHARGES	2,591,542.10	CONTRACTUAL ALLOW	1,736,122.32
NON-COVERD CHARGES	79,973.35	TOTAL MEDICAID LIAB	855,419.78
		LESS: COB	20,492.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	834,927.22

TOTAL NUMBER OF ADMISSIONS 172

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	432		0	282,713.00		255.40
ROUTINE NURSERY	69		0	44,386.90		1,868.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	501		0	327,099.90		2,123.90
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	95		0	108,142.40		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	95		0	108,142.40		0.00
TOTAL ACCOMODATIONS	596		0	435,242.30		2,123.90

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	536,987.79	0.00	OTHER LAB	8,633.30	0.00
MED/SURG SUPPLY	278,215.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	441,174.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,230.20	1,062.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,242.30	34,947.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,422.28	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,159.90	0.00	MRI SERVICES	17,831.80	0.00
IV THERAPY	5,508.70	18,041.39	PROFESSIONAL FEES	0.00	1,019.66
OPERATING ROOM	140,083.57	3,956.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	62,096.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	154,329.28	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,948.80	0.00	AMBULANCE	0.00	5,280.00
GI SERVICES	8,542.40	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,156.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,588.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,872.76	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,479.12	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	138,707.54	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,811.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,173.00	13,542.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,606.10	0.00			
AUDIOLOGY	17,837.50	0.00			
CARDIOLOGY	9,954.90	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	906.36	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,798.90	0.00			
			TOTAL ANCILLARY	2,156,299.80	77,849.45
			TOTAL ACCOMODATIONS	435,242.30	2,123.90
			TOTAL CHARGES	2,591,542.10	79,973.35

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,952,020.98	ADJUSTMENTS	12,250.19
COVERED CHARGES	1,669,956.46	CONTRACTUAL ALLOW	1,235,924.16
NON-COVERD CHARGES	282,064.52	TOTAL MEDICAID LIAB	434,032.30
		LESS: COB	2,015.32
		LESS: COPAYMENT	1,136.14
		REIMBURSEMENT	430,880.84
		ALL OTHER	386,015.12
		FEE SCHEDULE-LAB	44,865.72
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,439

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,416.96	6,123.18	OTHER LAB	19,335.80	0.00
MED/SURG SUPPLY	75,097.62	1,466.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	359.80	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	153,570.03	4,611.74	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	150,527.74	111,449.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	581.80	2,242.30	FEE SCHEDULE LAB	503,392.50	32,383.00
EKG/ECG	31,544.20	3,882.20	MRI SERVICES	96,171.63	7,110.50
IV THERAPY	13,560.80	15,324.30	PROFESSIONAL FEES	0.00	380.80
OPERATING ROOM	45,470.66	7,301.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,016.52	4,475.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	54,832.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	263,189.70	56,765.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,597.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,004.60	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,295.40	1,815.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,599.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,992.20	11,833.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,948.10	11,631.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,740.92	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,866.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,208.60	903.90			
			TOTAL ANCILLARY	1,669,956.46	282,064.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,669,956.46	282,064.52

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: 08/29/2018
Run Time: 00:53:13
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,787.31	ADJUSTMENTS	0.00
COVERED CHARGES	10,722.06	CONTRACTUAL ALLOW	7,459.86
NON-COVERD CHARGES	4,065.25	TOTAL MEDICAID LIAB	3,262.20
		LESS: COB	3,259.20
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	805.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	437.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,252.50	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	3,642.80	708.50
EKG/ECG	0.00	178.70	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	142.45	PROFESSIONAL FEES	0.00	1,238.70
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,972.00	649.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	478.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	347.80	669.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,264.90	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,722.06	4,065.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,722.06	4,065.25

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	173,797.33	ADJUSTMENTS	97.00
COVERED CHARGES	153,347.11	CONTRACTUAL ALLOW	142,897.11
NON-COVERD CHARGES	20,450.22	TOTAL MEDICAID LIAB	10,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	408.00
		REIMBURSEMENT	10,042.00
		TOTAL NUMBER OF CLAIMS	209

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,610.63	36.02	OTHER LAB	1,250.20	0.00
MED/SURG SUPPLY	3,225.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,019.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,929.90	7,632.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,770.80	2,569.50
EKG/ECG	1,250.90	178.70	MRI SERVICES	0.00	0.00
IV THERAPY	809.60	1,556.10	PROFESSIONAL FEES	0.00	410.70
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	208.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,842.00	6,630.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	164.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	822.40	834.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	906.36	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	537.10	602.60			
			TOTAL ANCILLARY	153,347.11	20,450.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	153,347.11	20,450.22

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,221.43	ADJUSTMENTS	0.00
COVERED CHARGES	2,946.73	CONTRACTUAL ALLOW	563.11
NON-COVERD CHARGES	1,274.70	TOTAL MEDICAID LIAB	2,383.62
		LESS: COB	2,383.62
		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86.63	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	72.20	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	1,358.80	34.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,429.10	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	478.30			
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	2,946.73	1,274.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,946.73	1,274.70

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

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,245.32	ADJUSTMENTS	0.00
COVERED CHARGES	38,968.48	CONTRACTUAL ALLOW	28,783.64
NON-COVERD CHARGES	276.84	TOTAL MEDICAID LIAB	10,184.84
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	10,178.84
		TOTAL NUMBER OF CLAIMS	2

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,637.48	174.24	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,075.16	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	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	102.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,670.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	798.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,359.24	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,968.48	276.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,968.48	276.84

Report : 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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,960.01	ADJUSTMENTS	0.00
COVERED CHARGES	21,599.21	CONTRACTUAL ALLOW	6,065.36
NON-COVERD CHARGES	5,360.80	TOTAL MEDICAID LIAB	15,533.85
		LESS: COB	15,530.85
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,171.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,493.40	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	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	93.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,129.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	2,137.80	AMBULANCE	0.00	0.00
GI SERVICES	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	12,108.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,599.21	5,360.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,599.21	5,360.80

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

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

Run Date: 08/29/2018
 Run Time: 00:40:58
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,707,748.31	ADJUSTMENTS	27,557.65
COVERED CHARGES	3,661,297.98	CONTRACTUAL ALLOW	2,014,521.44
NON-COVERD CHARGES	46,450.33	TOTAL MEDICAID LIAB	1,646,776.54
		LESS: COB	25,762.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,621,014.08

TOTAL NUMBER OF ADMISSIONS 213

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	509		0	358,879.00		16,320.17
ROUTINE NURSERY	45		0	26,786.25		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	554		0	385,665.25		16,320.17
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	295		0	403,251.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	295		0	403,251.00		0.00
TOTAL ACCOMODATIONS	849		0	788,916.25		16,320.17

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	294,700.38	0.00	OTHER LAB	19,857.82	0.00
MED/SURG SUPPLY	303,258.44	502.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	521,832.13	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,233.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	227,533.65	4,505.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,831.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,054.23	0.00	MRI SERVICES	21,690.89	0.00
IV THERAPY	30,068.58	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	115,417.69	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,906.06	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	131,703.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	185.13	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,572.04	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	141,140.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,185.13	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,517.66	0.00	INJECTABLE DRUGS	644,763.33	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	4,726.54	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	13,469.72	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,130.23	361.72	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	115,849.71	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,588.12	6,035.29			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,557.68	18,725.26			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	32,903.58	0.00			
AUDIOLOGY	1,899.80	0.00			
CARDIOLOGY	67,712.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,626.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,466.61	0.00			
			TOTAL ANCILLARY	2,872,381.73	30,130.16
			TOTAL ACCOMODATIONS	788,916.25	16,320.17
			TOTAL CHARGES	3,661,297.98	46,450.33

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,883.38	ADJUSTMENTS	0.00
COVERED CHARGES	11,714.86	CONTRACTUAL ALLOW	8,148.04
NON-COVERD CHARGES	168.52	TOTAL MEDICAID LIAB	3,566.82
		LESS: COB	3,566.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,780.00		168.52
ROUTINE NURSERY	0		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	2,780.00		168.52
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	2,780.00		168.52

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,563.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	878.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,105.42	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,309.98	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	255.86	0.00	INJECTABLE DRUGS	1,492.04	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	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	0.00
OTHER IMAGING SERVICE	270.43	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,934.86	0.00
			TOTAL ACCOMODATIONS	2,780.00	168.52
			TOTAL CHARGES	11,714.86	168.52

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,505,839.53	ADJUSTMENTS	176,701.05
COVERED CHARGES	5,131,134.14	CONTRACTUAL ALLOW	4,017,654.50
NON-COVERD CHARGES	374,705.39	TOTAL MEDICAID LIAB	1,113,479.64
		LESS: COB	10,307.01
		LESS: COPAYMENT	3,144.00
		REIMBURSEMENT	1,100,028.63
		ALL OTHER	880,337.75
		FEE SCHEDULE-LAB	181,326.91
		INJECTABLE DRUGS	38,363.97

TOTAL NUMBER OF CLAIMS 3,961

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,727.63	2,285.94	OTHER LAB	21,250.05	521.99
MED/SURG SUPPLY	201,969.75	4,278.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	211,653.27	1,057.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	844,518.35	29,565.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,122.72	5,160.97	FEE SCHEDULE LAB	1,095,852.24	45,366.27
EKG/ECG	52,800.47	403.88	MRI SERVICES	111,301.59	4,473.96
IV THERAPY	95,681.16	1,127.57	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	182,296.51	9,025.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,023.65	85.85	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,200.22	4,879.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	370.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,266.94	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,173,444.89	5,459.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,122.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	199,469.75	43,710.24
RADIOLOGY THERAPEUTIC	234,167.03	125,987.77	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,168.10	629.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,195.94	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	680.00	2,400.31	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,364.85	2,873.18
LITHOTRIPSY	19,096.34	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	148,163.61	13,209.73			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	46,561.82	24,145.73			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	87,418.57	43,076.94			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,141.30	1,461.05			
AMBULATORY SURGERY	287.59	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,553.45	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,263.14	3,519.30			
			TOTAL ANCILLARY	5,131,134.14	374,705.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,131,134.14	374,705.39

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,737.15	ADJUSTMENTS	0.00
COVERED CHARGES	9,525.29	CONTRACTUAL ALLOW	2,364.57
NON-COVERD CHARGES	8,211.86	TOTAL MEDICAID LIAB	7,160.72
		LESS: COB	7,142.72
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	320.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,594.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,642.53	13.01
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	697.45	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,774.72	82.38	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	369.03	64.38
RADIOLOGY THERAPEUTIC	651.75	7,405.97	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	331.32	270.30			
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	9,525.29	8,211.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,525.29	8,211.86

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	164,890.22	ADJUSTMENTS	432.52
COVERED CHARGES	161,549.27	CONTRACTUAL ALLOW	146,454.50
NON-COVERD CHARGES	3,340.95	TOTAL MEDICAID LIAB	15,094.77
		LESS: COB	158.79
		LESS: COPAYMENT	410.11
		REIMBURSEMENT	14,525.87
		TOTAL NUMBER OF CLAIMS	267

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	614.10	21.46	OTHER LAB	479.34	0.00
MED/SURG SUPPLY	1,364.53	376.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,329.86	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,806.13	1,084.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,570.24	828.45
EKG/ECG	1,009.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,825.02	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	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	95,482.46	200.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,860.30	269.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	62.93	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,207.59	397.59			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	161,549.27	3,340.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	161,549.27	3,340.95

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	878.86	ADJUSTMENTS	0.00
COVERED CHARGES	878.86	CONTRACTUAL ALLOW	604.98
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	273.88
		LESS: COB	270.88
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

OCONEE REGIONAL MEDICAL CENTER
 821 N COBB ST
 MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
 000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150.29	0.00	OTHER THERAPEUTIC SVC	0.00	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	697.10	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	11.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	878.86	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	878.86	0.00

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

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

Run Date: 08/29/2018
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

OCONEE REGIONAL MEDICAL CENTER
821 N COBB ST
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,528.54	ADJUSTMENTS	16,419.15
COVERED CHARGES	65,515.53	CONTRACTUAL ALLOW	43,607.33
NON-COVERD CHARGES	13.01	TOTAL MEDICAID LIAB	21,908.20
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	21,893.20

TOTAL NUMBER OF CLAIMS 4

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	706.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,646.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	422.69	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	2,172.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	393.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,832.05	0.00
RADIOLOGY THERAPEUTIC	4,151.98	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,222.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,288.36	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,679.02	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	65,515.53	13.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,515.53	13.01

Report : 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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000151A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,028,546.58	ADJUSTMENTS	31,739.84
COVERED CHARGES	1,742,086.75	CONTRACTUAL ALLOW	1,133,659.69
NON-COVERD CHARGES	286,459.83	TOTAL MEDICAID LIAB	608,427.06
		LESS: COB	5,271.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	603,155.53

TOTAL NUMBER OF ADMISSIONS 99

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	533		15	319,800.00		275,382.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	533		15	319,800.00		275,382.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	23		0	33,557.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	33,557.00		0.00
TOTAL ACCOMODATIONS	556		15	353,357.00		275,382.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	302,173.30	0.00	OTHER LAB	5,853.00	0.00
MED/SURG SUPPLY	81,776.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	167,789.36	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,535.61	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,373.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,249.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,708.00	0.00	MRI SERVICES	3,491.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,383.90	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	213,035.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,507.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,087.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,534.54	0.00	INJECTABLE DRUGS	5,292.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,048.38	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,191.49	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	314,580.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,525.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,996.88	9,343.23			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,005.00	1,734.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,615.86	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	19,803.00	0.00			
			TOTAL ANCILLARY	1,388,729.75	11,077.83
			TOTAL ACCOMODATIONS	353,357.00	275,382.00
			TOTAL CHARGES	1,742,086.75	286,459.83

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

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 01/01/17 THROUGH 12/31/17
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: 08/29/2018
Run Time: 00:06:52
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,767,480.10	ADJUSTMENTS	43,453.53
COVERED CHARGES	1,598,956.14	CONTRACTUAL ALLOW	1,310,652.58
NON-COVERD CHARGES	168,523.96	TOTAL MEDICAID LIAB	288,303.56
		LESS: COB	0.00
		LESS: COPAYMENT	1,142.87
		REIMBURSEMENT	287,160.69
		ALL OTHER	238,453.62
		FEE SCHEDULE-LAB	46,942.18
		INJECTABLE DRUGS	1,764.89
		TOTAL NUMBER OF CLAIMS	1,436

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,079.90	13,405.49	OTHER LAB	11,328.89	0.00
MED/SURG SUPPLY	27,391.00	5,376.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,685.24	9,066.61	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	252,710.00	15,410.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,086.14	6,114.00	FEE SCHEDULE LAB	392,676.03	29,146.98
EKG/ECG	18,963.00	258.00	MRI SERVICES	55,246.00	0.00
IV THERAPY	86,001.12	5,639.68	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	91,590.00	2,711.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,122.00	2,322.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,481.00	1,043.00	AMBULANCE	0.00	0.00
GI SERVICES	1,911.00	2,001.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	369,492.66	2,390.94	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,719.00	9,721.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,778.59	17,784.18
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	1,253.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	300.00	34,904.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,918.45	3,266.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,062.88	718.71			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,467.00	1,273.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,077.24	4,718.16			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,869.00	0.00			
			TOTAL ANCILLARY	1,598,956.14	168,523.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,598,956.14	168,523.96

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,372.47	ADJUSTMENTS	0.00
COVERED CHARGES	8,120.67	CONTRACTUAL ALLOW	4,186.24
NON-COVERD CHARGES	3,251.80	TOTAL MEDICAID LIAB	3,934.43
		LESS: COB	3,934.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	185.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	912.00	315.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,784.96	2,911.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	333.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	3,346.35	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	140.36	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,120.67	3,251.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,120.67	3,251.80

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: 08/29/2018
Run Time: 00:07:02
Page: 8

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	161,578.04	ADJUSTMENTS	267.70
COVERED CHARGES	158,499.86	CONTRACTUAL ALLOW	147,591.56
NON-COVERD CHARGES	3,078.18	TOTAL MEDICAID LIAB	10,908.30
		LESS: COB	0.00
		LESS: COPAYMENT	420.67
		REIMBURSEMENT	10,487.63
		TOTAL NUMBER OF CLAIMS	195

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,787.32	683.43	OTHER LAB	560.00	0.00
MED/SURG SUPPLY	396.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,198.00	339.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,905.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,475.77	1,405.07
EKG/ECG	903.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,923.97	104.43	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,236.00	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	90,765.93	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,317.87	546.25
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	2,031.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	158,499.86	3,078.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	158,499.86	3,078.18

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: 08/29/2018
Run Time: 00:07:04
Page: 10

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	720.66	ADJUSTMENTS	0.00
COVERED CHARGES	720.66	CONTRACTUAL ALLOW	587.71
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	132.95
		LESS: COB	132.95
		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: 08/29/2018
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 Page: 11

SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	153.18	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	567.48	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	720.66	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	720.66	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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
Run Time: 00:07:04
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
 Run Time: 00:25:37
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	164,134.25	ADJUSTMENTS	0.00
COVERED CHARGES	158,214.25	CONTRACTUAL ALLOW	97,315.88
NON-COVERD CHARGES	5,920.00	TOTAL MEDICAID LIAB	60,898.37
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	60,898.37
TOTAL NUMBER OF ADMISSIONS			13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	47		0	34,247.00		4,052.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	47		0	34,247.00		4,052.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	47		0	34,247.00		4,052.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,728.50	0.00	OTHER LAB	998.00	0.00
MED/SURG SUPPLY	3,312.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,429.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,983.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,331.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	724.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,283.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,762.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,538.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	605.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	269.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,004.00	1,868.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	123,967.25	1,868.00
			TOTAL ACCOMODATIONS	34,247.00	4,052.00
			TOTAL CHARGES	158,214.25	5,920.00

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

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

Run Date: 08/29/2018
Run Time: 00:25:37
Page: 3

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 10/01/16 THROUGH 09/30/17
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: 08/29/2018
Run Time: 00:25:37
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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	853,681.60	ADJUSTMENTS	38,306.74
COVERED CHARGES	805,568.85	CONTRACTUAL ALLOW	520,664.54
NON-COVERD CHARGES	48,112.75	TOTAL MEDICAID LIAB	284,904.31
		LESS: COB	115.61
		LESS: COPAYMENT	510.00
		REIMBURSEMENT	284,278.70
		ALL OTHER	256,081.62
		FEE SCHEDULE-LAB	27,109.34
		INJECTABLE DRUGS	1,087.74

TOTAL NUMBER OF CLAIMS 833

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

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

Run Date: 08/29/2018
 Run Time: 00:25:37
 Page: 5

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,738.10	20.00	OTHER LAB	9,151.00	0.00
MED/SURG SUPPLY	9,816.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,651.00	1,017.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	144,008.00	27,510.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	297.00	FEE SCHEDULE LAB	186,129.75	11,437.00
EKG/ECG	12,127.00	181.00	MRI SERVICES	0.00	0.00
IV THERAPY	56,432.00	821.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	448.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,016.00	161.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,735.50	505.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	225.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	269.25	915.50	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	17,276.00	3,645.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,378.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,564.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,206.50	0.00			
			TOTAL ANCILLARY	805,568.85	48,112.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	805,568.85	48,112.75

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,938.42	ADJUSTMENTS	0.00
COVERED CHARGES	2,915.42	CONTRACTUAL ALLOW	952.87
NON-COVERD CHARGES	23.00	TOTAL MEDICAID LIAB	1,962.55
		LESS: COB	1,962.55
		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

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 1221 E MCPHERSON AVE 000000173A SERVICE DATES 10/01/16 THROUGH 09/30/17
 NASHVILLE,GA 31639-2326 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	102.75	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	2,114.50	23.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	630.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,915.42	23.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,915.42	23.00

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: 08/29/2018
Run Time: 00:25:40
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,154.56	ADJUSTMENTS	273.70
COVERED CHARGES	58,111.56	CONTRACTUAL ALLOW	51,007.18
NON-COVERD CHARGES	2,043.00	TOTAL MEDICAID LIAB	7,104.38
		LESS: COB	0.00
		LESS: COPAYMENT	228.00
		REIMBURSEMENT	6,876.38
		TOTAL NUMBER OF CLAIMS	127

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,687.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	470.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,336.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,964.00	1,452.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,246.00	591.00
EKG/ECG	1,086.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,996.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,120.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,206.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	58,111.56	2,043.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,111.56	2,043.00

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

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

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HOSPITAL AUTHORITY OF 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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000195A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	80,446.30	ADJUSTMENTS	0.00
COVERED CHARGES	78,725.90	CONTRACTUAL ALLOW	21,299.34
NON-COVERD CHARGES	1,720.40	TOTAL MEDICAID LIAB	57,426.56
		LESS: COB	6,602.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	50,824.21

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	42		0	19,525.00		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	42		0	19,525.00		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	42		0	19,525.00		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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,305.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,563.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,507.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,099.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,050.80	1,720.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,289.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	235.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,682.70	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	4,249.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,879.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	247.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	412.50	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	17.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	1,881.00	0.00			
			TOTAL ANCILLARY	59,200.90	1,720.40
			TOTAL ACCOMODATIONS	19,525.00	0.00
			TOTAL CHARGES	78,725.90	1,720.40

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

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

Run Date: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
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: 08/29/2018
Run Time: 00:49:13
Page: 4

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	467,337.33	ADJUSTMENTS	19,490.36
COVERED CHARGES	457,348.23	CONTRACTUAL ALLOW	200,258.14
NON-COVERD CHARGES	9,989.10	TOTAL MEDICAID LIAB	257,090.09
		LESS: COB	89.06
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	256,608.03
		ALL OTHER	227,505.51
		FEE SCHEDULE-LAB	22,917.91
		INJECTABLE DRUGS	6,184.61

TOTAL NUMBER OF CLAIMS 705

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,866.34	0.00	OTHER LAB	41,019.08	0.00
MED/SURG SUPPLY	12,340.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,326.95	192.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,013.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	189.75	0.00	FEE SCHEDULE LAB	151,539.87	5,495.90
EKG/ECG	10,641.30	220.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,550.00	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	5,612.00	591.80	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	118,384.31	258.50	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	15,536.14	3,016.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	214.75	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	2,030.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,908.40	0.00			
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	2,307.26	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,300.80	0.00			
			TOTAL ANCILLARY	457,348.23	9,989.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	457,348.23	9,989.10

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

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

Run Date: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,727.90	ADJUSTMENTS	0.00
COVERED CHARGES	3,521.50	CONTRACTUAL ALLOW	1,135.98
NON-COVERD CHARGES	206.40	TOTAL MEDICAID LIAB	2,385.52
		LESS: COB	2,385.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	67.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	99.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,948.40	206.40
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,093.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60.50	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	3,521.50	206.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,521.50	206.40

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: 08/29/2018
Run Time: 00:49:18
Page: 8

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,433.00	ADJUSTMENTS	144.00
COVERED CHARGES	56,381.00	CONTRACTUAL ALLOW	51,631.00
NON-COVERD CHARGES	1,052.00	TOTAL MEDICAID LIAB	4,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	210.00
		REIMBURSEMENT	4,540.00
		TOTAL NUMBER OF CLAIMS	95

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,548.10	390.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,167.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,268.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,602.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,031.15	423.00
EKG/ECG	750.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	454.30	44.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,721.50	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	2,838.05	195.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	56,381.00	1,052.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,381.00	1,052.00

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: 08/29/2018
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BLECKLEY MEMORIAL HOSP
 145 E PEACOCK ST
 COCHRAN,GA 31014-7846

PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
000000195A	SERVICE DATES	04/01/16	THROUGH	03/31/17
	ADMISSION DATES	00/00/00	THROUGH	00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,402.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,367.40	CONTRACTUAL ALLOW	835.13
NON-COVERD CHARGES	35.00	TOTAL MEDICAID LIAB	532.27
		LESS: COB	532.27
		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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37.40	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	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	670.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	565.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60.50	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	1,367.40	35.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,367.40	35.00

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

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,147.90	ADJUSTMENTS	0.00
COVERED CHARGES	9,482.90	CONTRACTUAL ALLOW	4,620.01
NON-COVERD CHARGES	665.00	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

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,167.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,221.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	1,544.35	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	552.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,457.20	220.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	524.50	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	1,342.05	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	475.20	0.00			
			TOTAL ANCILLARY	9,482.90	665.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,482.90	665.00

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: 08/29/2018
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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	04/01/16	THROUGH	03/31/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,787,957.38	ADJUSTMENTS	586,580.28
COVERED CHARGES	28,001,378.23	CONTRACTUAL ALLOW	23,288,483.33
NON-COVERD CHARGES	786,579.15	TOTAL MEDICAID LIAB	4,712,894.90
		LESS: COB	16,769.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,696,125.82

TOTAL NUMBER OF ADMISSIONS 637

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	748		0	461,936.00		406,280.00
ROUTINE NURSERY	236		0	159,290.00		135,636.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	984		0	621,226.00		541,916.00
SPECIAL CARE SERVICES						
CCU	284		0	507,688.00		0.00
ICU	1,265		0	2,081,791.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,589,479.00		0.00
TOTAL ACCOMODATIONS	2,533		0	3,210,705.00		541,916.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,389,039.07	0.00	OTHER LAB	86,433.17	0.00
MED/SURG SUPPLY	1,111,599.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,736,421.89	0.00	EDUCATION & TRAINING	8,696.44	0.00
RADIOLOGY-DIAGNOSTIC	557,115.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,636,335.23	14,602.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	197,475.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	95,630.25	0.00	MRI SERVICES	336,857.73	0.00
IV THERAPY	3,146.08	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,870,803.63	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	350,376.20	1,625.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,109,557.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	661,853.64	0.00	AMBULANCE	0.00	0.00
GI SERVICES	273,934.74	168,353.64	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,639,101.32	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	259,008.09	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	159,590.37	0.00	INJECTABLE DRUGS	1,936,529.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,865.88	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,642.33	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	156,602.61	8,632.89	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,707.18	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,147,462.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,397.14
OTHER IMAGING SERVICE	136,331.98	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	134,243.06	30,010.76			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	57,615.05	8,041.00			
AUDIOLOGY	46,880.97	0.00			
CARDIOLOGY	1,390,639.16	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,016.32	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	169,160.77	0.00			
			TOTAL ANCILLARY	24,790,673.23	244,663.15
			TOTAL ACCOMODATIONS	3,210,705.00	541,916.00
			TOTAL CHARGES	28,001,378.23	786,579.15

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: 08/29/2018
Run Time: 00:16:38
Page: 3

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217234001518	06/19/17 - 06/23/17	08/28/17	0.00	1,817.34	0.00	0.00	0.00
614	2217317000544	10/01/16 - 10/22/16	11/20/17	0.00	4,796.00	0.00	0.00	0.00
615	2018104028713	01/28/17 - 01/31/17	04/23/18	0.00	3,261.44	0.00	0.00	0.00
615	2018160025003	09/03/17 - 09/07/17	06/18/18	0.00	3,522.36	0.00	0.00	0.00
TOTAL				0.00	13,397.14	0.00	0.00	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
 1499 FAIR RD
 STATESBORO,GA 30458-1683

PROVIDER NUMBER
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	530,068.32	ADJUSTMENTS	0.00
COVERED CHARGES	513,295.41	CONTRACTUAL ALLOW	467,177.15
NON-COVERD CHARGES	16,772.91	TOTAL MEDICAID LIAB	46,118.26
		LESS: COB	46,118.26
		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	19		0	11,498.00		11,074.00
ROUTINE NURSERY	6		0	3,732.00		3,694.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	25		0	15,230.00		14,768.00
SPECIAL CARE SERVICES						
CCU	17		0	31,212.00		0.00
ICU	10		0	16,200.00		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	27		0	47,412.00		0.00
TOTAL ACCOMODATIONS	52		0	62,642.00		14,768.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
 1499 FAIR RD
 STATESBORO,GA 30458-1683

PROVIDER NUMBER
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,008.67	0.00	OTHER LAB	1,445.56	0.00
MED/SURG SUPPLY	5,630.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	78,518.28	0.00	EDUCATION & TRAINING	73.01	0.00
RADIOLOGY-DIAGNOSTIC	21,386.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,846.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	978.32	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	813.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,348.68	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,621.42	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	624.68	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,720.41	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,094.81	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,341.08	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,882.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,420.16	0.00	INJECTABLE DRUGS	9,742.98	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	628.46	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	53,492.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,817.34
OTHER IMAGING SERVICE	2,679.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,347.84	187.57			
AUDIOLOGY	1,473.86	0.00			
CARDIOLOGY	45,533.40	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	450,653.41	2,004.91
			TOTAL ACCOMODATIONS	62,642.00	14,768.00
			TOTAL CHARGES	513,295.41	16,772.91

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: 08/29/2018
Run Time: 00:16:43
Page: 6

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR RD
STATESBORO,GA 30458-1683

PROVIDER NUMBER
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2318016000030	02/19/17 - 02/28/17	02/05/18	0.00	1,817.34	0.00	9,663.27	0.00
TOTAL				0.00	1,817.34	0.00	9,663.27	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: 08/29/2018
Run Time: 00:16:44
Page: 7

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,590,595.76	ADJUSTMENTS	585,737.66
COVERED CHARGES	25,428,198.40	CONTRACTUAL ALLOW	23,220,720.09
NON-COVERD CHARGES	3,162,397.36	TOTAL MEDICAID LIAB	2,207,478.31
		LESS: COB	27,109.72
		LESS: COPAYMENT	4,014.74
		REIMBURSEMENT	2,176,353.85
		ALL OTHER	2,004,282.40
		FEE SCHEDULE-LAB	140,958.48
		INJECTABLE DRUGS	31,112.97

TOTAL NUMBER OF CLAIMS 4,499

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

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

Run Date: 08/29/2018
 Run Time: 00:16:44
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	854,944.10	11,622.92	OTHER LAB	559,485.00	17,341.77
MED/SURG SUPPLY	639,553.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	509.39	EDUCATION & TRAINING	0.00	3,794.63
RADIOLOGY-DIAGNOSTIC	986,280.69	41,043.31	OTHER THERAPEUTIC SVC	0.00	10,537.85
CT SCAN	2,412,766.53	218,898.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	6,710.29	FEE SCHEDULE LAB	2,988,688.05	97,317.16
EKG/ECG	107,509.96	8,480.38	MRI SERVICES	657,012.24	15,008.13
IV THERAPY	41,987.14	10,193.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,119,488.63	881,042.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	263,549.26	363,793.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	531,420.15	173,770.21	AMBULANCE	0.00	0.00
GI SERVICES	706,153.23	58,561.93	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,125,468.65	91,320.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	588,206.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	927,553.17	131,581.91
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	2,921.91	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	40,603.65	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	45,060.62	5,858.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,299.48	599,052.16
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	497,994.94	95,534.98			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,050.20	2,590.32			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,738.52	30,564.09			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,644,084.29	148,415.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,970.64	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	478,932.95	95,326.61			
			TOTAL ANCILLARY	25,428,198.40	3,162,397.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,428,198.40	3,162,397.36

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	494,124.46	ADJUSTMENTS	0.00
COVERED CHARGES	377,796.70	CONTRACTUAL ALLOW	202,124.91
NON-COVERD CHARGES	116,327.76	TOTAL MEDICAID LIAB	175,671.79
		LESS: COB	175,617.79
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80

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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,863.82	0.00	OTHER LAB	29,191.22	0.00
MED/SURG SUPPLY	5,236.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,827.77	491.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,616.91	25,906.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	51,741.23	1,122.42
EKG/ECG	1,016.50	203.30	MRI SERVICES	8,828.35	0.00
IV THERAPY	3,397.70	372.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,360.61	36,660.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,192.05	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,699.56	11,362.03	AMBULANCE	0.00	0.00
GI SERVICES	14,979.59	25,107.69	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,446.86	97.72	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,481.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,804.45	938.10
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	371.78	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	125.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,819.78	10,781.49			
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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,895.96	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,024.30	3,158.33			
			TOTAL ANCILLARY	377,796.70	116,327.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	377,796.70	116,327.76

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

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

Run Date: 08/29/2018
Run Time: 00:17:06
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,856,741.42	ADJUSTMENTS	2,044.20
COVERED CHARGES	2,786,922.58	CONTRACTUAL ALLOW	2,747,773.73
NON-COVERD CHARGES	69,818.84	TOTAL MEDICAID LIAB	39,148.85
		LESS: COB	143.67
		LESS: COPAYMENT	1,264.52
		REIMBURSEMENT	37,740.66
		TOTAL NUMBER OF CLAIMS	698

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,696.13	325.73	OTHER LAB	27,622.12	10,103.15
MED/SURG SUPPLY	8,194.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	73.01
RADIOLOGY-DIAGNOSTIC	115,652.45	2,094.78	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	304,443.22	4,888.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	678.43	FEE SCHEDULE LAB	298,731.44	6,630.40
EKG/ECG	6,582.34	0.00	MRI SERVICES	5,212.77	3,522.36
IV THERAPY	7,295.20	1,825.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,276.91	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,306.81	1,994.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,065.06	511.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,678,639.74	11,889.17	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,034.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108,023.86	3,704.37
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	248.41	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,931.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	53,322.71	7,884.17			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,974.58	342.58			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	26,062.73	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,785.59	9,171.77			
			TOTAL ANCILLARY	2,786,922.58	69,818.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,786,922.58	69,818.84

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

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

Run Date: 08/29/2018
Run Time: 00:17:09
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,348.29	ADJUSTMENTS	0.00
COVERED CHARGES	63,830.22	CONTRACTUAL ALLOW	44,859.04
NON-COVERD CHARGES	1,518.07	TOTAL MEDICAID LIAB	18,971.18
		LESS: COB	18,944.18
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 17

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,064.49	0.00	OTHER LAB	1,280.45	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,089.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,146.92	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,564.98	72.72
EKG/ECG	203.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,064.33	268.44	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	4,284.06	70.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,132.19	1,106.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	63,830.22	1,518.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,830.22	1,518.07

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,202,120.04	ADJUSTMENTS	88,644.36
COVERED CHARGES	2,366,038.86	CONTRACTUAL ALLOW	2,210,772.42
NON-COVERD CHARGES	836,081.18	TOTAL MEDICAID LIAB	155,266.44
		LESS: COB	0.00
		LESS: COPAYMENT	129.83
		REIMBURSEMENT	155,136.61

TOTAL NUMBER OF CLAIMS 28

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,497.91	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	291,010.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	65.00
RADIOLOGY-DIAGNOSTIC	21,103.41	10,841.12	OTHER THERAPEUTIC SVC	0.00	2,244.15
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,653.08	370.98
EKG/ECG	813.20	813.20	MRI SERVICES	0.00	0.00
IV THERAPY	1,008.63	2,648.49	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,147,554.69	83,992.76	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	207,211.40	5,417.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,693.97	20,165.68	AMBULANCE	0.00	0.00
GI SERVICES	23,978.97	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	389.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	126,701.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,228.88	6,979.48
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	1,198.44	2,792.36	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	146,296.80	696,331.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	165,496.79	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	35,200.29	3,418.96			
			TOTAL ANCILLARY	2,366,038.86	836,081.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,366,038.86	836,081.18

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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
 Run Time: 00:33:15
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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 06/01/16 THROUGH 05/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	234,220.73	ADJUSTMENTS	6,312.53
COVERED CHARGES	229,270.73	CONTRACTUAL ALLOW	141,905.79
NON-COVERD CHARGES	4,950.00	TOTAL MEDICAID LIAB	87,364.94
		LESS: COB	1,435.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	85,929.68

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	60		0	34,560.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	60		0	34,560.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	60		0	34,560.00		0.00

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 06/01/16 THROUGH 05/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,658.00	0.00	OTHER LAB	478.25	0.00
MED/SURG SUPPLY	23,276.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,508.50	0.00	EDUCATION & TRAINING	402.00	0.00
RADIOLOGY-DIAGNOSTIC	7,201.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,204.36	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	226.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,354.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,594.56	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,776.50	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	14,892.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,086.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	256.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	921.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,504.00	4,950.00			
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	1,164.19	0.00			
			TOTAL ANCILLARY	194,710.73	4,950.00
			TOTAL ACCOMODATIONS	34,560.00	0.00
			TOTAL CHARGES	229,270.73	4,950.00

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	06/01/16	THROUGH	05/31/17
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: 08/29/2018
Run Time: 00:33:15
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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 06/01/16 THROUGH 05/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,150,287.62	ADJUSTMENTS	36,019.38
COVERED CHARGES	1,013,599.88	CONTRACTUAL ALLOW	740,583.65
NON-COVERD CHARGES	136,687.74	TOTAL MEDICAID LIAB	273,016.23
		LESS: COB	211.78
		LESS: COPAYMENT	618.00
		REIMBURSEMENT	272,186.45
		ALL OTHER	252,142.17
		FEE SCHEDULE-LAB	19,069.54
		INJECTABLE DRUGS	974.74

TOTAL NUMBER OF CLAIMS 878

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

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

Run Date: 08/29/2018
 Run Time: 00:33:15
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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 06/01/16 THROUGH 05/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,415.46	1,686.50	OTHER LAB	2,450.67	0.00
MED/SURG SUPPLY	30,667.99	6.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	268.00
RADIOLOGY-DIAGNOSTIC	58,408.74	5,174.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	104,440.58	12,788.76	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	226.00	FEE SCHEDULE LAB	133,818.00	15,981.00
EKG/ECG	14,073.00	2,025.00	MRI SERVICES	12,830.22	0.00
IV THERAPY	62,479.86	16,586.10	PROFESSIONAL FEES	0.00	200.00
OPERATING ROOM	13,931.67	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,272.25	23,020.91	FREE STANDING CLINIC	640.00	60.00
ANESTHESIA	3,950.96	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,610.47	6,147.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	402,671.71	33,644.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,128.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,467.10	9,823.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	256.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	264.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,406.59	2,324.03			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,413.00	2,555.54			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,762.59	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,761.02	3,650.00			
			TOTAL ANCILLARY	1,013,599.88	136,687.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,013,599.88	136,687.74

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

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

Run Date: 08/29/2018
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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 06/01/16 THROUGH 05/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,894.66	ADJUSTMENTS	0.00
COVERED CHARGES	6,735.11	CONTRACTUAL ALLOW	2,661.95
NON-COVERD CHARGES	2,159.55	TOTAL MEDICAID LIAB	4,073.16
		LESS: COB	4,070.16
		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

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 06/01/16 THROUGH 05/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134.00	197.00	OTHER LAB	478.25	0.00
MED/SURG SUPPLY	223.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,419.00	137.00
EKG/ECG	225.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	908.75	117.50	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	116.50	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	3,147.75	1,708.05	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	82.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,735.11	2,159.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,735.11	2,159.55

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: 08/29/2018
Run Time: 00:33:18
Page: 8

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

PROVIDER NUMBER
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 06/01/16 THROUGH 05/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	151,749.23	ADJUSTMENTS	55.94
COVERED CHARGES	144,890.02	CONTRACTUAL ALLOW	137,058.42
NON-COVERD CHARGES	6,859.21	TOTAL MEDICAID LIAB	7,831.60
		LESS: COB	0.00
		LESS: COPAYMENT	269.82
		REIMBURSEMENT	7,561.78
		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 06/01/16 THROUGH 05/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,436.50	157.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,954.82	16.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,180.00	269.37	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,059.43	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,319.00	567.75
EKG/ECG	1,299.00	450.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,376.91	1,448.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,485.25	3,142.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	786.08	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	99,922.75	400.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,412.00	107.50
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	507.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,151.00	300.00			
			TOTAL ANCILLARY	144,890.02	6,859.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	144,890.02	6,859.21

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

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

Run Date: 08/29/2018
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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	06/01/16	THROUGH	05/31/17
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

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	06/01/16	THROUGH	05/31/17
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

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	06/01/16	THROUGH	05/31/17
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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	942,954.49	ADJUSTMENTS	6,814.07
COVERED CHARGES	925,366.49	CONTRACTUAL ALLOW	676,866.42
NON-COVERD CHARGES	17,588.00	TOTAL MEDICAID LIAB	248,500.07
		LESS: COB	6,474.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	242,025.33

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	94		0	92,552.00		12,293.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	94		0	92,552.00		12,293.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	47		0	94,517.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	94,517.00		0.00
TOTAL ACCOMODATIONS	141		0	187,069.00		12,293.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,937.88	0.00	OTHER LAB	1,855.00	0.00
MED/SURG SUPPLY	77,014.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	156,282.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,144.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,089.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,496.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,154.00	0.00	MRI SERVICES	7,374.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,640.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,687.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,591.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,236.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	14,388.00	0.00	INJECTABLE DRUGS	118,643.61	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	698.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,687.00
OTHER IMAGING SERVICE	4,031.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,020.00	1,608.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,728.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,289.00	0.00			
			TOTAL ANCILLARY	738,297.49	5,295.00
			TOTAL ACCOMODATIONS	187,069.00	12,293.00
			TOTAL CHARGES	925,366.49	17,588.00

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017048065146	02/05/17 - 02/08/17	02/20/17	0.00	3,687.00	0.00	0.00	0.00
TOTAL				0.00	3,687.00	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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
Run Time: 00:54:25
Page: 5

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

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,837,280.88	ADJUSTMENTS	28,801.21
COVERED CHARGES	2,713,545.89	CONTRACTUAL ALLOW	2,158,314.76
NON-COVERD CHARGES	123,734.99	TOTAL MEDICAID LIAB	555,231.13
		LESS: COB	1,024.00
		LESS: COPAYMENT	1,098.00
		REIMBURSEMENT	553,109.13
		ALL OTHER	512,529.27
		FEE SCHEDULE-LAB	37,856.88
		INJECTABLE DRUGS	2,722.98
		TOTAL NUMBER OF CLAIMS	1,109

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

PROVIDER NUMBER
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,040.85	0.00	OTHER LAB	7,684.00	0.00
MED/SURG SUPPLY	275,730.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,431.00	6,163.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	395,121.00	9,657.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,279.00	1,557.00	FEE SCHEDULE LAB	543,946.99	20,435.40
EKG/ECG	69,489.00	0.00	MRI SERVICES	83,286.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	383,164.00	23,713.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,711.00	2,314.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	489,480.00	3,375.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	120,414.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50,792.05	20,311.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	684.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,584.00	4,469.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,844.00	6,432.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,728.00	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	45,821.00	19,260.00			
			TOTAL ANCILLARY	2,713,545.89	123,734.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,713,545.89	123,734.99

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: 08/29/2018
Run Time: 00:54:29
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
Run Time: 00:54:29
Page: 8

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

PROVIDER NUMBER
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	157,675.97	ADJUSTMENTS	0.00
COVERED CHARGES	154,065.97	CONTRACTUAL ALLOW	149,165.97
NON-COVERD CHARGES	3,610.00	TOTAL MEDICAID LIAB	4,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	208.41
		REIMBURSEMENT	4,691.59
		TOTAL NUMBER OF CLAIMS	98

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,665.74	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,807.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,770.00	1,284.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,245.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37,570.00	1,414.00
EKG/ECG	2,826.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	582.00	119.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,592.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,008.23	363.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	430.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	154,065.97	3,610.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	154,065.97	3,610.00

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: 08/29/2018
Run Time: 00:54:29
Page: 10

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

PROVIDER NUMBER
000000316A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/29/2018
Run Time: 00:54:29
Page: 11

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,194.05	ADJUSTMENTS	0.00
COVERED CHARGES	44,118.05	CONTRACTUAL ALLOW	39,255.16
NON-COVERD CHARGES	76.00	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,859.89

TOTAL NUMBER OF CLAIMS 1

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	1,814.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	41,202.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	103.00	76.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	44,118.05	76.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	44,118.05	76.00

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

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

Run Date: 08/29/2018
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Page: 13

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000316A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,974,649.17	ADJUSTMENTS	743,650.93
COVERED CHARGES	37,425,467.87	CONTRACTUAL ALLOW	25,981,587.46
NON-COVERD CHARGES	1,549,181.30	TOTAL MEDICAID LIAB	11,443,880.41
		LESS: COB	115,936.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,327,944.40

TOTAL NUMBER OF ADMISSIONS 1,269

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,864		0	3,917,888.00		198,645.00
ROUTINE NURSERY	1,243		0	2,454,385.00		3,657.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,107		0	6,372,273.00		202,302.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	663		0	1,804,686.00		0.00
NICU	167		0	552,039.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	830		0	2,356,725.00		0.00
TOTAL ACCOMODATIONS	5,937		0	8,728,998.00		202,302.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,165,652.33	4,015.19	OTHER LAB	212,459.59	0.00
MED/SURG SUPPLY	2,914,613.87	1,163.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,093,091.82	964.08	EDUCATION & TRAINING	37,525.65	0.00
RADIOLOGY-DIAGNOSTIC	688,172.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,302,020.42	899,117.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	167,496.55	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	302,840.00	0.00	MRI SERVICES	467,852.32	0.00
IV THERAPY	114,058.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,431,689.91	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	440,785.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,829,017.40	14,049.26	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	421,601.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	251,896.05	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,443,695.37	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	288,907.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	172,741.84	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	88,924.18	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	78,633.87	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	224,364.00	23,110.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	43,979.96	1,365.70	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	889,275.12	1,146.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	292,066.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	384,433.62	9,514.78			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	528,730.74	95,127.49			
AUDIOLOGY	9,421.65	297,305.40			
CARDIOLOGY	2,237,617.23	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	33,702.72	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139,201.95	0.00			
			TOTAL ANCILLARY	28,696,469.87	1,346,879.30
			TOTAL ACCOMODATIONS	8,728,998.00	202,302.00
			TOTAL CHARGES	37,425,467.87	1,549,181.30

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

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

Run Date: 08/29/2018
 Run Time: 00:43:26
 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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,087,166.54	ADJUSTMENTS	0.00
COVERED CHARGES	1,077,044.96	CONTRACTUAL ALLOW	952,669.88
NON-COVERD CHARGES	10,121.58	TOTAL MEDICAID LIAB	124,375.08
		LESS: COB	124,375.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	45		0	45,482.00		648.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	45		0	45,482.00		648.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,722.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,722.00		0.00
TOTAL ACCOMODATIONS	46		0	48,204.00		648.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,200.07	0.00	OTHER LAB	2,871.15	0.00
MED/SURG SUPPLY	143,816.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	40,069.39	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,142.76	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,198.89	8,564.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,478.07	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,345.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	447.71	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,469.35	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,110.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,388.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,416.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,826.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,425.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,581.50	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	19,368.30	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	98.70	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,143.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,397.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,250.04	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,502.10	909.30			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	585,582.97	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,709.90	0.00			
			TOTAL ANCILLARY	1,028,840.96	9,473.58
			TOTAL ACCOMODATIONS	48,204.00	648.00
			TOTAL CHARGES	1,077,044.96	10,121.58

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

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

Run Date: 08/29/2018
Run Time: 00:43:27
Page: 5

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,846,284.09	ADJUSTMENTS	278,026.81
COVERED CHARGES	16,960,907.97	CONTRACTUAL ALLOW	14,642,582.22
NON-COVERD CHARGES	1,885,376.12	TOTAL MEDICAID LIAB	2,318,325.75
		LESS: COB	277.11
		LESS: COPAYMENT	3,825.95
		REIMBURSEMENT	2,314,222.69
		ALL OTHER	2,107,760.85
		FEE SCHEDULE-LAB	185,997.59
		INJECTABLE DRUGS	20,464.25

TOTAL NUMBER OF CLAIMS 4,600

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148,886.95	11,938.37	OTHER LAB	291,000.74	7,751.64
MED/SURG SUPPLY	495,356.58	62,806.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	106.73
RADIOLOGY-DIAGNOSTIC	699,099.24	47,194.51	OTHER THERAPEUTIC SVC	0.00	3,895.81
CT SCAN	1,827,925.53	394,274.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,709.48	32,596.87	FEE SCHEDULE LAB	4,626,689.40	418,984.95
EKG/ECG	226,460.00	19,430.00	MRI SERVICES	247,649.14	17,903.30
IV THERAPY	211,558.39	29,135.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,049,315.05	90,103.26	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	80,540.52	4,521.79	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	82,529.27	197,939.09	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	295,059.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	237,525.40	33,184.55	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,612,671.07	130,127.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	220,768.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	238,175.44	74,025.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,188.94	8,225.37	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	17,461.95	495.60	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,993.22	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	62,795.63	4,951.46	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	102,698.34	13,611.58
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	833,964.03	133,079.24			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,142.88	864.98			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,447.79	71,063.66			
AUDIOLOGY	158.96	0.00			
CARDIOLOGY	198,358.96	74,708.10			
AMBULATORY SURGERY	4,943.40	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,826.64	463.05			
			TOTAL ANCILLARY	16,960,907.97	1,885,376.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,960,907.97	1,885,376.12

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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,872.57	ADJUSTMENTS	0.00
COVERED CHARGES	33,424.31	CONTRACTUAL ALLOW	20,691.03
NON-COVERD CHARGES	3,448.26	TOTAL MEDICAID LIAB	12,733.28
		LESS: COB	12,731.45
		LESS: COPAYMENT	1.83
		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

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	277.56	1,742.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	874.00	691.43	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,939.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,034.21	204.60
EKG/ECG	1,005.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	522.09	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,657.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	232.03	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	784.35	809.73			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,424.31	3,448.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,424.31	3,448.26

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	295,209.88	ADJUSTMENTS	161.82
COVERED CHARGES	283,070.64	CONTRACTUAL ALLOW	273,448.96
NON-COVERD CHARGES	12,139.24	TOTAL MEDICAID LIAB	9,621.68
		LESS: COB	0.00
		LESS: COPAYMENT	291.51
		REIMBURSEMENT	9,330.17
		TOTAL NUMBER OF CLAIMS	172

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,336.77	0.00	OTHER LAB	3,345.30	0.00
MED/SURG SUPPLY	266.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,992.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,169.70	4,802.13	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67,969.43	2,400.58
EKG/ECG	3,350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,195.71	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	968.18	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	171,444.46	1,051.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,351.17	736.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,680.28	3,148.30			
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	283,070.64	12,139.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	283,070.64	12,139.24

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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
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

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

PROVIDER NUMBER
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	443,136.60	ADJUSTMENTS	22,165.92
COVERED CHARGES	395,003.48	CONTRACTUAL ALLOW	356,186.87
NON-COVERD CHARGES	48,133.12	TOTAL MEDICAID LIAB	38,816.61
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	38,792.61

TOTAL NUMBER OF CLAIMS 7

SUMMARY TYPE VII
 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 01/01/17 THROUGH 12/31/17
 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	2,147.43	67.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	67,698.46	12,451.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,315.67	11,845.65	OTHER THERAPEUTIC SVC	0.00	454.12
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,357.55	204.60
EKG/ECG	0.00	335.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	1,241.37	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	220,263.15	1,011.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,997.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,484.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,128.95	791.43
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,375.92	14,221.20
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	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	5,509.27			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,155.00	0.00			
			TOTAL ANCILLARY	395,003.48	48,133.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	395,003.48	48,133.12

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

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	01/01/17	THROUGH	12/31/17
RIVERDALE,GA 30274-2615		ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000415A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	252,930.23	ADJUSTMENTS	0.00
COVERED CHARGES	251,769.23	CONTRACTUAL ALLOW	86,007.00
NON-COVERD CHARGES	1,161.00	TOTAL MEDICAID LIAB	165,762.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	165,762.23

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	83		0	33,200.00		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	83		0	33,200.00		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	83		0	33,200.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,724.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,328.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	39,803.59	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,712.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,899.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	441.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,280.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,002.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,255.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	766.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,104.00	1,161.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,083.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	170.00	0.00			
			TOTAL ANCILLARY	218,569.23	1,161.00
			TOTAL ACCOMODATIONS	33,200.00	0.00
			TOTAL CHARGES	251,769.23	1,161.00

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
Run Time: 00:50:33
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	566,356.28	ADJUSTMENTS	2,197.16
COVERED CHARGES	530,874.57	CONTRACTUAL ALLOW	248,241.30
NON-COVERD CHARGES	35,481.71	TOTAL MEDICAID LIAB	282,633.27
		LESS: COB	0.00
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	282,174.27
		ALL OTHER	259,831.87
		FEE SCHEDULE-LAB	22,342.40
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 735

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,843.02	0.00	OTHER LAB	3,522.00	0.00
MED/SURG SUPPLY	27,507.82	308.71	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,390.00	2,379.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	104,059.25	5,952.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,931.00	52.00	FEE SCHEDULE LAB	174,935.48	9,308.00
EKG/ECG	13,888.00	3,736.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,819.00	650.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,656.00	581.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,690.00	8,386.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	560.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,058.00	1,098.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,166.00	1,083.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,890.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,959.00	1,948.00			
			TOTAL ANCILLARY	530,874.57	35,481.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	530,874.57	35,481.71

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,214.75	ADJUSTMENTS	0.00
COVERED CHARGES	2,722.25	CONTRACTUAL ALLOW	-437.52
NON-COVERD CHARGES	1,492.50	TOTAL MEDICAID LIAB	3,159.77
		LESS: COB	3,159.77
		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

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

PROVIDER NUMBER
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	168.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	201.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	351.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,492.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	992.00	0.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	847.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,722.25	1,492.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,722.25	1,492.50

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,280.62	ADJUSTMENTS	47.00
COVERED CHARGES	55,658.62	CONTRACTUAL ALLOW	50,458.62
NON-COVERD CHARGES	2,622.00	TOTAL MEDICAID LIAB	5,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	4,984.00
		TOTAL NUMBER OF CLAIMS	104

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,410.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,655.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,018.00	117.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,809.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,003.13	883.00
EKG/ECG	810.00	440.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	219.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,310.00	1,182.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	423.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	55,658.62	2,622.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	55,658.62	2,622.00

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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

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

PROVIDER NUMBER
000000415A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000426A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,750,752.00	ADJUSTMENTS	3,347,647.68
COVERED CHARGES	89,301,768.45	CONTRACTUAL ALLOW	71,612,824.88
NON-COVERD CHARGES	4,448,983.55	TOTAL MEDICAID LIAB	17,688,943.57
		LESS: COB	110,973.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,577,970.28

TOTAL NUMBER OF ADMISSIONS 2,202

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,204		0	8,762,672.00		2,677,558.00
ROUTINE NURSERY	950		0	702,570.00		6,594.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,154		0	9,465,242.00		2,684,152.00
SPECIAL CARE SERVICES						
CCU	2,077		0	4,757,645.64		252,272.36
ICU	722		0	2,475,517.00		10,329.00
NICU	1,860		0	6,124,441.50		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	254		0	1,138,778.00		161,370.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,913		0	14,496,382.14		423,971.36
TOTAL ACCOMODATIONS	13,067		0	23,961,624.14		3,108,123.36

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,466,854.65	312,345.00	OTHER LAB	646,805.00	6,899.00
MED/SURG SUPPLY	2,796,707.91	131,415.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,611,646.80	180,928.00	EDUCATION & TRAINING	76,006.00	0.00
RADIOLOGY-DIAGNOSTIC	1,564,064.00	28,887.00	OTHER THERAPEUTIC SVC	0.00	10,287.00
CT SCAN	3,429,066.00	13,099.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	568,271.33	13,114.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	609,708.00	4,470.00	MRI SERVICES	932,788.00	15,279.00
IV THERAPY	913,286.00	12,422.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,830,995.00	56,640.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,659,706.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,184,086.00	107,436.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,032,720.00	27,680.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,894,976.00	10,228.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	952,141.00	138.00	DRUG-SPECIFIC/HOME IV	0.00	2,809.00
LABORATORY PATHOLOGIC	391,838.00	1,491.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	250,442.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	462,463.83	6,395.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	244,581.95	2,413.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,476,418.00	11,976.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	79,920.00	6,447.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	393,745.00	0.00	IMPL DEV CHARGE PATIENTS	2,134,079.23	3,939.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,924.00
OTHER IMAGING SERVICE	617,360.50	13,278.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,034,404.00	342,269.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	433,407.00	1,743.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,830,254.50	6,678.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	215,928.00	1,680.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	605,474.61	6,550.00			
			TOTAL ANCILLARY	65,340,144.31	1,340,860.19
			TOTAL ACCOMODATIONS	23,961,624.14	3,108,123.36
			TOTAL CHARGES	89,301,768.45	4,448,983.55

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: 08/29/2018
Run Time: 00:39:41
Page: 3

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9817307000162	09/21/16 - 10/11/16	11/13/17	0.00	1,924.00	0.00	0.00	0.00
TOTAL				0.00	1,924.00	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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,783,002.73	ADJUSTMENTS	0.00
COVERED CHARGES	1,776,128.73	CONTRACTUAL ALLOW	855,361.71
NON-COVERD CHARGES	6,874.00	TOTAL MEDICAID LIAB	920,767.02
		LESS: COB	920,767.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	66		2	81,180.00		6,676.00
ROUTINE NURSERY	23		0	11,364.00		198.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	89		2	92,544.00		6,874.00
SPECIAL CARE SERVICES						
CCU	24		0	57,840.00		0.00
ICU	6		0	20,658.00		0.00
NICU	131		0	429,811.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	161		0	508,309.00		0.00
TOTAL ACCOMODATIONS	250		2	600,853.00		6,874.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	200,405.00	0.00	OTHER LAB	20,611.00	0.00
MED/SURG SUPPLY	55,130.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	170,305.00	0.00	EDUCATION & TRAINING	5,324.00	0.00
RADIOLOGY-DIAGNOSTIC	27,138.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,263.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,746.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,493.00	0.00	MRI SERVICES	10,037.00	0.00
IV THERAPY	13,463.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,446.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	219,698.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,144.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,633.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,104.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,483.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,143.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,546.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	59,880.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,665.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,013.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,508.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,958.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,223.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,165.25	0.00			
			TOTAL ANCILLARY	1,175,275.73	0.00
			TOTAL ACCOMODATIONS	600,853.00	6,874.00
			TOTAL CHARGES	1,776,128.73	6,874.00

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,866,052.04	ADJUSTMENTS	449,271.77
COVERED CHARGES	29,194,398.91	CONTRACTUAL ALLOW	24,964,221.39
NON-COVERD CHARGES	3,671,653.13	TOTAL MEDICAID LIAB	4,230,177.52
		LESS: COB	54,070.05
		LESS: COPAYMENT	6,701.94
		REIMBURSEMENT	4,169,405.53
		ALL OTHER	3,605,187.26
		FEE SCHEDULE-LAB	427,001.14
		INJECTABLE DRUGS	137,217.13

TOTAL NUMBER OF CLAIMS 9,482

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

PROVIDER NUMBER
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	846,593.48	10,736.50	OTHER LAB	773,513.00	0.00
MED/SURG SUPPLY	592,593.27	22,586.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	222.60	EDUCATION & TRAINING	0.00	75.00
RADIOLOGY-DIAGNOSTIC	1,534,363.00	15,024.00	OTHER THERAPEUTIC SVC	0.00	314.00
CT SCAN	3,178,419.00	742,903.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118,962.00	53,453.03	FEE SCHEDULE LAB	4,974,938.54	196,839.00
EKG/ECG	503,176.00	16,986.00	MRI SERVICES	732,541.00	88,084.00
IV THERAPY	1,866,914.00	11,453.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,788,390.00	278,185.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	139,767.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	109,595.00	117,719.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	840,440.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,244.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,407,322.00	12,199.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	621,731.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	259.70	INJECTABLE DRUGS	1,251,304.28	1,139,161.25
RADIOLOGY THERAPEUTIC	21,018.00	228.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,700.00	6,961.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,147.00	3,660.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	113,772.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	304,214.00	25,113.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	175,425.00	134,949.00	IMPL DEV CHARGE PATIENTS	182,571.88	11,518.88
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53.90
OTHER IMAGING SERVICE	792,366.00	381,187.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	104,036.00	1,471.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	365,480.00	136,395.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	480,464.00	143,294.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,652.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	445,518.46	6,849.20			
			TOTAL ANCILLARY	29,194,398.91	3,671,653.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,194,398.91	3,671,653.13

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5917093000090	03/10/17 - 03/10/17	04/10/17	0.00	53.90	0.00	0.00	0.00
TOTAL				0.00	53.90	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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	605,103.19	ADJUSTMENTS	0.00
COVERED CHARGES	473,357.91	CONTRACTUAL ALLOW	248,160.65
NON-COVERD CHARGES	131,745.28	TOTAL MEDICAID LIAB	225,197.26
		LESS: COB	225,140.13
		LESS: COPAYMENT	57.13
		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

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

PROVIDER NUMBER
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,135.75	1,291.25	OTHER LAB	27,311.00	0.00
MED/SURG SUPPLY	13,176.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,725.00	1,900.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,370.00	60,983.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	82,702.61	3,225.78
EKG/ECG	6,797.00	447.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,039.00	296.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,823.00	24,772.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,453.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,004.00	1,081.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,432.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	115,699.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,549.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,662.75	2,536.25
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	1,005.00	691.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	862.00	2,840.00	IMPL DEV CHARGE PATIENTS	103.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,745.00	26,188.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,420.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,519.00	240.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,811.00	5,254.00			
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	4,012.92	0.00			
			TOTAL ANCILLARY	473,357.91	131,745.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	473,357.91	131,745.28

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,397,379.68	ADJUSTMENTS	768.16
COVERED CHARGES	1,307,226.68	CONTRACTUAL ALLOW	1,275,042.63
NON-COVERD CHARGES	90,153.00	TOTAL MEDICAID LIAB	32,184.05
		LESS: COB	913.59
		LESS: COPAYMENT	816.00
		REIMBURSEMENT	30,454.46
		TOTAL NUMBER OF CLAIMS	559

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,752.00	405.00	OTHER LAB	56,773.00	1,941.00
MED/SURG SUPPLY	7,362.04	203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,028.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	112,226.00	32,752.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	291,842.00	10,284.00
EKG/ECG	24,138.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	58,330.00	822.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,868.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,236.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,109.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,560.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	595,771.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,333.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	203.75	930.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	5,345.00	12,542.00	IMPL DEV CHARGE PATIENTS	820.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,232.00	30,163.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,297.89	0.00			
			TOTAL ANCILLARY	1,307,226.68	90,153.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,307,226.68	90,153.00

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

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

Run Date: 08/29/2018
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,207.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,151.00	CONTRACTUAL ALLOW	1,137.36
NON-COVERD CHARGES	56.00	TOTAL MEDICAID LIAB	2,013.64
		LESS: COB	2,007.64
		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: 08/29/2018
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	56.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	666.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,485.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,151.00	56.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,151.00	56.00

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

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

Run Date: 08/29/2018
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,979,660.32	ADJUSTMENTS	145,549.86
COVERED CHARGES	3,743,710.08	CONTRACTUAL ALLOW	3,298,738.22
NON-COVERD CHARGES	235,950.24	TOTAL MEDICAID LIAB	444,971.86
		LESS: COB	0.00
		LESS: COPAYMENT	647.41
		REIMBURSEMENT	444,324.45
		TOTAL NUMBER OF CLAIMS	82

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191,137.18	0.00	OTHER LAB	304.00	0.00
MED/SURG SUPPLY	156,663.24	7,214.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,076.00	11,655.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,999.00	7,044.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	676.03	FEE SCHEDULE LAB	50,934.00	1,511.00
EKG/ECG	1,788.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	207,659.00	629.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	333,510.00	52,837.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,730.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	147,408.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,385.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	81,557.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,116,227.55	104,363.25
RADIOLOGY THERAPEUTIC	7,068.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,055.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,978.00	4,754.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	176,018.68	18,645.80
LITHOTRIPSY	34,256.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,150.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,222.00	1,471.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	188,473.00	22,713.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,166.43	1,382.00			
			TOTAL ANCILLARY	3,743,710.08	235,950.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,743,710.08	235,950.24

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: 08/29/2018
Run Time: 00:40:31
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	125,667.00	ADJUSTMENTS	0.00
COVERED CHARGES	61,205.00	CONTRACTUAL ALLOW	-36,162.55
NON-COVERD CHARGES	64,462.00	TOTAL MEDICAID LIAB	97,367.55
		LESS: COB	97,355.55
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	935.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	281.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	730.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,756.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	51,590.50	64,462.00
RADIOLOGY THERAPEUTIC	912.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	61,205.00	64,462.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,205.00	64,462.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,660,380.77	ADJUSTMENTS	591,245.23
COVERED CHARGES	10,455,515.77	CONTRACTUAL ALLOW	7,404,637.23
NON-COVERD CHARGES	204,865.00	TOTAL MEDICAID LIAB	3,050,878.54
		LESS: COB	60,672.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,990,206.48

TOTAL NUMBER OF ADMISSIONS 348

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,172		0	847,303.00		44,415.00
ROUTINE NURSERY	52		0	37,291.00		785.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,224		0	884,594.00		45,200.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	249		0	343,463.00		0.00
NICU	1		0	810.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	250		0	344,273.00		0.00
TOTAL ACCOMODATIONS	1,474		0	1,228,867.00		45,200.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,306,570.03	0.00	OTHER LAB	70,389.00	0.00
MED/SURG SUPPLY	510,215.00	454.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,893,482.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	242,007.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	498,764.00	24,763.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	96,127.27	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	252,939.00	0.00	MRI SERVICES	65,162.00	0.00
IV THERAPY	133,389.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,340,346.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	41,103.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	639,766.99	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	163,081.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	103,025.00	9,360.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	231,086.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,428.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	37,500.00
LABORATORY PATHOLOGIC	23,283.00	0.00	INJECTABLE DRUGS	125,898.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,436.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,170.18	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	32,706.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	540.00	650.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	661,573.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,594.00
OTHER IMAGING SERVICE	37,918.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,229.00	76,041.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,353.00	5,303.00			
AUDIOLOGY	8,052.00	0.00			
CARDIOLOGY	433,502.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,264.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	162,844.23	0.00			
			TOTAL ANCILLARY	9,226,648.77	159,665.00
			TOTAL ACCOMODATIONS	1,228,867.00	45,200.00
			TOTAL CHARGES	10,455,515.77	204,865.00

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: 08/29/2018
Run Time: 00:26:22
Page: 3

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2317352000122	10/04/17 - 10/10/17	01/01/18	0.00	2,797.00	0.00	2,426.25	0.00
615	2318058000281	12/07/17 - 12/10/17	03/12/18	0.00	2,797.00	0.00	0.00	0.00
TOTAL				0.00	5,594.00	0.00	2,426.25	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: 08/29/2018
 Run Time: 00:26:24
 Page: 4

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,263.00	ADJUSTMENTS	0.00
COVERED CHARGES	69,814.00	CONTRACTUAL ALLOW	30,447.06
NON-COVERD CHARGES	1,449.00	TOTAL MEDICAID LIAB	39,366.94
		LESS: COB	39,366.94
		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	18		0	12,825.00		1,449.00
ROUTINE NURSERY	4		0	2,920.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	22		0	15,745.00		1,449.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	15,745.00		1,449.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,567.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,233.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,422.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	268.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,082.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	400.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	771.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,804.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,616.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,559.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,066.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,590.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	418.00	0.00	INJECTABLE DRUGS	8,158.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,434.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	488.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,193.00	0.00			
			TOTAL ANCILLARY	54,069.00	0.00
			TOTAL ACCOMODATIONS	15,745.00	1,449.00
			TOTAL CHARGES	69,814.00	1,449.00

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,832,566.52	ADJUSTMENTS	593,782.54
COVERED CHARGES	11,401,085.38	CONTRACTUAL ALLOW	9,622,317.59
NON-COVERD CHARGES	431,481.14	TOTAL MEDICAID LIAB	1,778,767.79
		LESS: COB	5,203.41
		LESS: COPAYMENT	5,013.87
		REIMBURSEMENT	1,768,550.51
		ALL OTHER	1,569,275.99
		FEE SCHEDULE-LAB	168,845.13
		INJECTABLE DRUGS	30,429.39

TOTAL NUMBER OF CLAIMS 4,298

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	416,119.99	279.00	OTHER LAB	78,141.00	0.00
MED/SURG SUPPLY	323,000.00	6,476.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	742.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	511,857.99	12,136.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,442,146.00	36,984.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	53,938.00	5,465.00	FEE SCHEDULE LAB	2,089,915.94	107,692.00
EKG/ECG	213,600.99	1,000.00	MRI SERVICES	331,235.00	19,518.00
IV THERAPY	586,025.99	66,502.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,103,798.50	15,634.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	593.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	208,655.00	10,321.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	254,929.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	189,802.17	9,890.83	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,255,551.10	2,560.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	62,124.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	190,403.18	52,584.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	402.00	338.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	610.00	0.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,578.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	108,849.00	4,680.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	178,912.00	729.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	175,533.00	8,265.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,536.00	10,710.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	405,450.00	6,356.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	512,305.00	33,768.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,432.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	674,219.53	17,272.70			
			TOTAL ANCILLARY	11,401,085.38	431,481.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,401,085.38	431,481.14

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

Run Date: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,784.03	ADJUSTMENTS	0.00
COVERED CHARGES	35,844.51	CONTRACTUAL ALLOW	16,321.71
NON-COVERD CHARGES	8,939.52	TOTAL MEDICAID LIAB	19,522.80
		LESS: COB	19,511.88
		LESS: COPAYMENT	10.92
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 33

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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,091.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,179.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,232.00	6,082.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,455.00	323.99
EKG/ECG	200.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,451.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,190.50	2,190.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,198.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127.00	38.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	305.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,278.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,900.00	0.00			
			TOTAL ANCILLARY	35,844.51	8,939.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,844.51	8,939.52

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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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	386,298.32	ADJUSTMENTS	538.40
COVERED CHARGES	382,909.32	CONTRACTUAL ALLOW	362,155.57
NON-COVERD CHARGES	3,389.00	TOTAL MEDICAID LIAB	20,753.75
		LESS: COB	40.25
		LESS: COPAYMENT	597.06
		REIMBURSEMENT	20,116.44
		TOTAL NUMBER OF CLAIMS	372

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,850.00	5.00	OTHER LAB	1,195.00	0.00
MED/SURG SUPPLY	2,571.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,746.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,396.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	90,263.99	2,436.00
EKG/ECG	3,400.00	0.00	MRI SERVICES	3,240.00	0.00
IV THERAPY	20,896.00	169.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,551.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	167,298.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,661.00	324.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,105.00	455.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,736.32	0.00			
			TOTAL ANCILLARY	382,909.32	3,389.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	382,909.32	3,389.00

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

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

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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,246.01	ADJUSTMENTS	0.00
COVERED CHARGES	5,219.01	CONTRACTUAL ALLOW	3,311.51
NON-COVERD CHARGES	27.00	TOTAL MEDICAID LIAB	1,907.50
		LESS: COB	1,901.44
		LESS: COPAYMENT	6.06
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	90.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	258.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,921.96	27.00
EKG/ECG	199.99	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	96.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	427.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,140.06	0.00	SPECIAL SERVICES	0.00	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	5,219.01	27.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,219.01	27.00

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

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

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

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

PROVIDER NUMBER
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,450,674.34	ADJUSTMENTS	138,549.75
COVERED CHARGES	1,428,237.34	CONTRACTUAL ALLOW	1,278,516.13
NON-COVERD CHARGES	22,437.00	TOTAL MEDICAID LIAB	149,721.21
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	149,637.21
		TOTAL NUMBER OF CLAIMS	27

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,891.00	0.00	OTHER LAB	2,660.00	0.00
MED/SURG SUPPLY	72,247.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,322.00	15,752.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,427.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	545.00	680.00	FEE SCHEDULE LAB	12,459.00	571.00
EKG/ECG	2,400.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,362.00	1,012.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	459,548.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,562.00	546.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,945.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,210.00	144.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,348.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	142,315.00	1,358.00
RADIOLOGY THERAPEUTIC	1,436.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	303,778.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	840.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,088.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	352,942.34	1,286.00			
			TOTAL ANCILLARY	1,428,237.34	22,437.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,428,237.34	22,437.00

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: 08/29/2018
Run Time: 00:26:47
Page: 16

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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
 Run Time: 00:42:56
 Page: 1

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

PROVIDER NUMBER 000000459A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,436,930.40	ADJUSTMENTS	566,413.20
COVERED CHARGES	47,443,507.90	CONTRACTUAL ALLOW	38,205,393.61
NON-COVERD CHARGES	3,993,422.50	TOTAL MEDICAID LIAB	9,238,114.29
		LESS: COB	100,007.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,138,106.95

TOTAL NUMBER OF ADMISSIONS 1,062

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,783		0	4,670,116.00		3,473,129.00
ROUTINE NURSERY	129		0	95,031.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,912		0	4,765,147.00		3,473,129.00
SPECIAL CARE SERVICES						
CCU	224		0	492,695.00		0.00
ICU	488		0	1,782,458.00		0.00
NICU	315		0	1,360,235.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	53		0	190,278.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,080		0	3,825,666.00		0.00
TOTAL ACCOMODATIONS	5,992		0	8,590,813.00		3,473,129.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,042,466.81	97.75	OTHER LAB	292,910.25	0.00
MED/SURG SUPPLY	1,572,334.25	1,707.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,382,730.38	1,230.00	EDUCATION & TRAINING	27.00	0.00
RADIOLOGY-DIAGNOSTIC	1,406,980.75	0.00	OTHER THERAPEUTIC SVC	0.00	909.00
CT SCAN	2,100,123.75	377,237.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	956,060.88	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	303,475.75	0.00	MRI SERVICES	584,091.75	0.00
IV THERAPY	17,425.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,988,842.90	749.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	258,211.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,325,237.50	1,326.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	803,382.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	226,609.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,129,032.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	576,434.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	108,529.00
LABORATORY PATHOLOGIC	143,556.50	0.00	INJECTABLE DRUGS	7,213,311.65	3,615.75
RADIOLOGY THERAPEUTIC	2,636.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	707,600.92	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	250,214.36	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	293,019.75	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,931.00	129.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,351.25	0.00	IMPL DEV CHARGE PATIENTS	532,709.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	413,774.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	369,588.50	24,761.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	119,859.75	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,756,840.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,527.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	59,396.25	0.00			
			TOTAL ANCILLARY	38,852,694.90	520,293.50
			TOTAL ACCOMODATIONS	8,590,813.00	3,473,129.00
			TOTAL CHARGES	47,443,507.90	3,993,422.50

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

PROVIDER NUMBER
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	2016320004502	10/11/16 - 10/22/16	11/21/16	0.00	0.00	0.00	0.00	0.00
24	2016323005851	10/20/16 - 11/04/16	11/21/16	0.00	0.00	0.00	0.00	0.00
24	2016329052526	11/04/16 - 11/15/16	11/28/16	0.00	0.00	0.00	0.00	0.00
24	2016335003583	11/07/16 - 11/23/16	12/05/16	0.00	0.00	0.00	0.00	0.00
24	2017003100699	12/12/16 - 12/23/16	01/09/17	0.00	0.00	0.00	0.00	0.00
24	2017031068444	01/13/17 - 01/26/17	02/06/17	0.00	0.00	0.00	0.00	0.00
24	2017040113093	01/24/17 - 02/04/17	02/13/17	0.00	0.00	0.00	0.00	0.00
24	2017065037524	02/15/17 - 02/27/17	03/13/17	0.00	0.00	0.00	0.00	0.00
24	2017079029090	03/03/17 - 03/13/17	03/27/17	0.00	0.00	0.00	0.00	0.00
24	2017079029109	03/03/17 - 03/13/17	03/27/17	0.00	0.00	0.00	0.00	0.00
24	2017158067818	05/24/17 - 05/31/17	06/12/17	0.00	0.00	0.00	0.00	0.00
24	2017167076902	05/18/17 - 05/19/17	06/26/17	0.00	0.00	0.00	0.00	0.00
24	2017196002703	05/24/17 - 06/09/17	07/24/17	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	277,317.75	ADJUSTMENTS	0.00
COVERED CHARGES	252,678.75	CONTRACTUAL ALLOW	195,508.44
NON-COVERD CHARGES	24,639.00	TOTAL MEDICAID LIAB	57,170.31
		LESS: COB	57,170.31
		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	25		0	24,200.00		24,639.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	25		0	24,200.00		24,639.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	11		0	48,411.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	48,411.00		0.00
TOTAL ACCOMODATIONS	36		0	72,611.00		24,639.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,462.50	0.00	OTHER LAB	2,590.00	0.00
MED/SURG SUPPLY	1,724.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,301.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,062.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,640.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	862.50	0.00	MRI SERVICES	6,111.50	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,264.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44.25	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	2,528.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,140.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	62,405.50	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.	1,747.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,260.25	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,921.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	180,067.75	0.00
			TOTAL ACCOMODATIONS	72,611.00	24,639.00
			TOTAL CHARGES	252,678.75	24,639.00

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: 08/29/2018
Run Time: 00:43:00
Page: 6

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

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,604,172.30	ADJUSTMENTS	44,757.34
COVERED CHARGES	14,682,625.62	CONTRACTUAL ALLOW	13,423,039.75
NON-COVERD CHARGES	1,921,546.68	TOTAL MEDICAID LIAB	1,259,585.87
		LESS: COB	327.00
		LESS: COPAYMENT	1,624.54
		REIMBURSEMENT	1,257,634.33
		ALL OTHER	1,116,356.87
		FEE SCHEDULE-LAB	133,766.16
		INJECTABLE DRUGS	7,511.30
		TOTAL NUMBER OF CLAIMS	3,721

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	234,125.74	6,420.68	OTHER LAB	168,346.25	2,369.50
MED/SURG SUPPLY	239,534.00	8,533.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,147,764.00	94,755.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,771,943.00	582,361.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	958.50	4,912.00	FEE SCHEDULE LAB	3,072,612.30	98,205.00
EKG/ECG	333,621.50	2,156.25	MRI SERVICES	136,098.50	26,514.00
IV THERAPY	373,917.75	4,558.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	800,317.38	534,303.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,523.75	318.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,412.75	5,886.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	318,378.00	90.00	AMBULANCE	0.00	0.00
GI SERVICES	254,681.37	36,056.88	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,148,635.25	14,701.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	265,719.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,022.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78,547.88	9,780.25
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	387.25	2,169.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,567.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,974.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	126,892.00	0.00
LITHOTRIPSY	17,037.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	359,343.75	190,766.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,961.50	7,691.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	58,173.75	48,895.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	559,799.00	230,745.25			
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	107,893.95	1,122.00			
			TOTAL ANCILLARY	14,682,625.62	1,921,546.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,682,625.62	1,921,546.68

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

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

Run Date: 08/29/2018
Run Time: 00:43:08
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	403,717.09	ADJUSTMENTS	0.00
COVERED CHARGES	217,810.96	CONTRACTUAL ALLOW	137,534.13
NON-COVERD CHARGES	185,906.13	TOTAL MEDICAID LIAB	80,276.83
		LESS: COB	80,258.13
		LESS: COPAYMENT	18.70
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 61

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

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

PROVIDER NUMBER
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,800.50	0.00	OTHER LAB	654.50	0.00
MED/SURG SUPPLY	5,664.75	314.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,402.25	1,177.75	OTHER THERAPEUTIC SVC	0.00	87.50
CT SCAN	20,439.25	18,603.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	57,022.57	7,605.00
EKG/ECG	7,095.75	0.00	MRI SERVICES	0.00	3,564.00
IV THERAPY	2,274.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,913.00	124,324.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	586.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,550.00	301.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,827.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,625.37	1,625.38	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,391.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,347.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,680.02	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	1,553.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,543.25	14,873.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	813.25	4,455.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,632.50	8,388.50			
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	3,580.25	0.00			
			TOTAL ANCILLARY	217,810.96	185,906.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	217,810.96	185,906.13

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,265,288.97	ADJUSTMENTS	485.46
COVERED CHARGES	1,178,580.22	CONTRACTUAL ALLOW	1,151,505.26
NON-COVERD CHARGES	86,708.75	TOTAL MEDICAID LIAB	27,074.96
		LESS: COB	0.00
		LESS: COPAYMENT	1,071.00
		REIMBURSEMENT	26,003.96
		TOTAL NUMBER OF CLAIMS	484

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,398.93	52.75	OTHER LAB	3,857.75	0.00
MED/SURG SUPPLY	3,055.50	107.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	133,634.25	3,258.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	211,634.50	40,382.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	262,337.14	7,572.25
EKG/ECG	16,701.00	0.00	MRI SERVICES	0.00	23,702.25
IV THERAPY	35,729.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	625.00	7,158.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,812.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,068.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	460,135.25	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	6,776.40	149.75
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	65.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,692.75	4,260.25			
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	1,122.00	0.00			
			TOTAL ANCILLARY	1,178,580.22	86,708.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,178,580.22	86,708.75

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

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

PROVIDER NUMBER
000000459A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,051.75	ADJUSTMENTS	0.00
COVERED CHARGES	24,506.00	CONTRACTUAL ALLOW	11,528.06
NON-COVERD CHARGES	6,545.75	TOTAL MEDICAID LIAB	12,977.94
		LESS: COB	12,956.94
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	428.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,133.25	552.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,150.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,013.00	843.50
EKG/ECG	862.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	88.75	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	11,894.00	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	39.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,506.00	6,545.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,506.00	6,545.75

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

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

PROVIDER NUMBER
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,511,004.93	ADJUSTMENTS	0.00
COVERED CHARGES	2,285,092.93	CONTRACTUAL ALLOW	2,169,490.96
NON-COVERD CHARGES	225,912.00	TOTAL MEDICAID LIAB	115,601.97
		LESS: COB	3,354.93
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	112,151.04
		TOTAL NUMBER OF CLAIMS	21

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,272.75	499.25	OTHER LAB	1,335.75	0.00
MED/SURG SUPPLY	162,571.25	703.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,653.75	5,503.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,871.25	0.00
EKG/ECG	6,860.75	431.25	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,179,858.75	116,353.25	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	25,441.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,576.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,717.43	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	0.00	1,219.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	129.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	696,859.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,791.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	133,183.25	101,073.50			
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	5,101.00	0.00			
			TOTAL ANCILLARY	2,285,092.93	225,912.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,285,092.93	225,912.00

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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER
000000459A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:48:44
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,511,208.95	ADJUSTMENTS	577,008.03
COVERED CHARGES	25,748,645.92	CONTRACTUAL ALLOW	19,033,135.45
NON-COVERD CHARGES	762,563.03	TOTAL MEDICAID LIAB	6,715,510.47
		LESS: COB	85,953.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,629,557.25

TOTAL NUMBER OF ADMISSIONS 593

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,727		0	1,364,330.00		534,495.00
ROUTINE NURSERY	321		0	412,350.00		169,947.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,048		0	1,776,680.00		704,442.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	654		0	1,629,870.00		0.00
NICU	2		0	12,159.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	656		0	1,642,029.00		0.00
TOTAL ACCOMODATIONS	2,704		0	3,418,709.00		704,442.00

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

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

Run Date: 08/29/2018
 Run Time: 00:48:44
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,522,981.10	0.00	OTHER LAB	212,405.00	0.00
MED/SURG SUPPLY	497,668.55	2,716.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,132,580.50	4,810.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	469,493.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,544,903.00	9,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	239,885.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	222,829.00	0.00	MRI SERVICES	180,599.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,813,408.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	341,570.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,810,305.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	238,404.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	159,958.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,618,212.00	2,415.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	370,298.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	89,638.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	43,079.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	159,922.66	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	75,054.04	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	388,391.00	10,516.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	42,653.00	5,195.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	999,620.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	161,007.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	303,223.00	12,789.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	48,509.00	10,180.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	415,416.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	67,839.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	160,082.00	0.00			
			TOTAL ANCILLARY	22,329,936.92	58,121.03
			TOTAL ACCOMODATIONS	3,418,709.00	704,442.00
			TOTAL CHARGES	25,748,645.92	762,563.03

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

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

Run Date: 08/29/2018
 Run Time: 00:48:47
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	263,430.34	ADJUSTMENTS	0.00
COVERED CHARGES	240,315.34	CONTRACTUAL ALLOW	150,853.86
NON-COVERD CHARGES	23,115.00	TOTAL MEDICAID LIAB	89,461.48
		LESS: COB	89,461.48
		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	32		0	25,280.00		12,108.00
ROUTINE NURSERY	9		0	7,110.00		11,007.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	41		0	32,390.00		23,115.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	3,157.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	3,157.00		0.00
TOTAL ACCOMODATIONS	42		0	35,547.00		23,115.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,337.93	0.00	OTHER LAB	4,202.00	0.00
MED/SURG SUPPLY	4,323.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	36,296.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,100.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,456.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,166.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	886.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,172.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,160.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,870.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,630.00	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	932.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,326.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,061.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,934.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,900.00	0.00			
			TOTAL ANCILLARY	204,768.34	0.00
			TOTAL ACCOMODATIONS	35,547.00	23,115.00
			TOTAL CHARGES	240,315.34	23,115.00

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: 08/29/2018
Run Time: 00:48:48
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,121,850.70	ADJUSTMENTS	277,880.01
COVERED CHARGES	17,619,446.32	CONTRACTUAL ALLOW	15,541,058.66
NON-COVERD CHARGES	3,502,404.38	TOTAL MEDICAID LIAB	2,078,387.66
		LESS: COB	39,471.41
		LESS: COPAYMENT	4,362.00
		REIMBURSEMENT	2,034,554.25
		ALL OTHER	1,744,791.69
		FEE SCHEDULE-LAB	164,332.15
		INJECTABLE DRUGS	125,430.41

TOTAL NUMBER OF CLAIMS 4,570

PIEDMONT NEWNAN HOSPITAL INC PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 745 POPLAR ROAD 000000492A SERVICE DATES 07/01/16 THROUGH 06/30/17
 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	356,559.03	83.20	OTHER LAB	188,864.00	5,709.00
MED/SURG SUPPLY	304,877.28	24,393.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	727,238.00	55,295.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,997,234.00	792,023.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,288.00	41,959.34	FEE SCHEDULE LAB	3,116,482.00	151,696.00
EKG/ECG	352,628.00	15,948.00	MRI SERVICES	181,138.00	93,410.00
IV THERAPY	120,571.00	5,356.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	887,921.00	287,706.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	78,745.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	139,080.00	85,965.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	175,333.00	965.00	AMBULANCE	0.00	0.00
GI SERVICES	283,417.00	57,688.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,557,500.00	235,299.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	326,285.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	872,577.98	665,840.75
RADIOLOGY THERAPEUTIC	213,117.00	312,234.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	9,668.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,247.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	21,032.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	121,844.00	23,946.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	72,573.09	133,132.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	460,875.00	163,039.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	46,750.00	20,097.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	152,567.00	187,383.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	243,341.00	102,767.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	289,426.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	333,214.94	4,522.00			
			TOTAL ANCILLARY	17,619,446.32	3,502,404.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,619,446.32	3,502,404.38

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	297,861.24	ADJUSTMENTS	0.00
COVERED CHARGES	232,980.04	CONTRACTUAL ALLOW	146,515.12
NON-COVERD CHARGES	64,881.20	TOTAL MEDICAID LIAB	86,464.92
		LESS: COB	86,437.24
		LESS: COPAYMENT	27.68
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 64

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,101.55	0.00	OTHER LAB	5,268.00	0.00
MED/SURG SUPPLY	7,237.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,792.00	490.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,759.00	27,196.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	500.00	FEE SCHEDULE LAB	46,249.00	1,678.00
EKG/ECG	4,430.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,807.00	18,700.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,943.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	548.00	284.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,551.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,831.00	3,278.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,367.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,528.41	1,860.20
RADIOLOGY THERAPEUTIC	1,376.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	643.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	452.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	401.86	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,915.00	8,604.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,839.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,972.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,260.00	0.00			
			TOTAL ANCILLARY	232,980.04	64,881.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	232,980.04	64,881.20

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

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

Run Date: 08/29/2018
Run Time: 00:49:02
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	450,600.05	ADJUSTMENTS	155.51
COVERED CHARGES	392,785.01	CONTRACTUAL ALLOW	381,355.60
NON-COVERD CHARGES	57,815.04	TOTAL MEDICAID LIAB	11,429.41
		LESS: COB	1,192.39
		LESS: COPAYMENT	304.98
		REIMBURSEMENT	9,932.04
		TOTAL NUMBER OF CLAIMS	183

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,236.04	0.00	OTHER LAB	1,635.00	0.00
MED/SURG SUPPLY	1,155.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,358.00	978.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,399.00	33,457.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,184.02	FEE SCHEDULE LAB	64,488.00	2,760.00
EKG/ECG	3,101.00	0.00	MRI SERVICES	0.00	4,060.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	528.00	264.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	236,498.00	5,249.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,308.89	2,411.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,208.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,520.00	3,417.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,188.00	1,827.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,900.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,470.08	0.00			
			TOTAL ANCILLARY	392,785.01	57,815.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	392,785.01	57,815.04

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,072.20	ADJUSTMENTS	0.00
COVERED CHARGES	19,342.16	CONTRACTUAL ALLOW	8,296.62
NON-COVERD CHARGES	11,730.04	TOTAL MEDICAID LIAB	11,045.54
		LESS: COB	11,033.54
		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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,818.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	11,440.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,431.00	250.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,350.00	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	439.20	40.04
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,342.16	11,730.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,342.16	11,730.04

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

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

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

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

PROVIDER NUMBER
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	412,879.58	ADJUSTMENTS	12,303.88
COVERED CHARGES	394,625.96	CONTRACTUAL ALLOW	351,499.38
NON-COVERD CHARGES	18,253.62	TOTAL MEDICAID LIAB	43,126.58
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	43,048.58

TOTAL NUMBER OF CLAIMS 7

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,472.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,201.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,571.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	683.02	FEE SCHEDULE LAB	1,589.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,483.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,494.00	12,435.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	284.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,811.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,028.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	243,637.41	2,262.60
RADIOLOGY THERAPEUTIC	5,208.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	81,059.56	2,652.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,787.00	0.00			
			TOTAL ANCILLARY	394,625.96	18,253.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	394,625.96	18,253.62

Report : 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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,544.64	ADJUSTMENTS	0.00
COVERED CHARGES	65,544.64	CONTRACTUAL ALLOW	34,195.56
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	31,349.08
		LESS: COB	31,343.08
		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	2,556.00	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	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
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	65,544.64	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,544.64	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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	96,175,187.31	ADJUSTMENTS	5,748,424.36
COVERED CHARGES	90,179,753.53	CONTRACTUAL ALLOW	60,778,441.70
NON-COVERD CHARGES	5,995,433.78	TOTAL MEDICAID LIAB	29,401,311.83
		LESS: COB	242,041.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,159,270.68

TOTAL NUMBER OF ADMISSIONS 2,078

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,425		1	15,713,894.00		1,017,925.00
ROUTINE NURSERY	994		0	1,414,380.00		7,507.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12,419		1	17,128,274.00		1,025,432.00
SPECIAL CARE SERVICES						
CCU	246		0	1,351,350.00		87,750.00
ICU	2,107		0	10,988,973.00		1,345,500.00
NICU	280		0	1,045,398.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,633		0	13,385,721.00		1,433,250.00
TOTAL ACCOMODATIONS	15,052		1	30,513,995.00		2,458,682.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,549,062.93	186,069.57	OTHER LAB	410,514.00	11,676.00
MED/SURG SUPPLY	4,172,674.87	221,555.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,853,626.00	415,482.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,124,552.00	26,846.50	OTHER THERAPEUTIC SVC	0.00	260,177.00
CT SCAN	2,519,622.00	43,422.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	858,126.49	12,280.04	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	358,805.00	2,410.50	MRI SERVICES	1,014,043.00	4,265.00
IV THERAPY	1,414.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,410,809.22	96,147.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	938,964.00	1,416.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,287,901.00	295,281.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,852,190.00	4,289.00	AMBULANCE	0.00	0.00
GI SERVICES	515,367.00	6,212.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,116,932.00	2,999.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	920,355.00	6,037.00	DRUG-SPECIFIC/HOME IV	0.00	514,218.84
LABORATORY PATHOLOGIC	442,149.00	4,183.00	INJECTABLE DRUGS	6,820,178.03	329,536.81
RADIOLOGY THERAPEUTIC	115,205.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	411,469.32	6,283.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	183,321.69	6,907.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,151,525.00	211,836.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	887.00	3,617.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,911,883.18	25,520.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	219,560.00
OTHER IMAGING SERVICE	325,268.00	360,645.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,529,959.80	59,705.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	114,990.00	132,641.00			
AUDIOLOGY	13,914.00	0.00			
CARDIOLOGY	2,443,590.00	25,874.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	259,966.00	37,438.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,494.00	2,222.00			
			TOTAL ANCILLARY	59,665,758.53	3,536,751.78
			TOTAL ACCOMODATIONS	30,513,995.00	2,458,682.00
			TOTAL CHARGES	90,179,753.53	5,995,433.78

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016264056793	09/10/16 - 09/13/16	09/26/16	0.00	8,530.00	0.00	0.00	0.00
615	2016281063138	09/28/16 - 10/02/16	10/17/16	0.00	8,530.00	0.00	0.00	0.00
615	2016318001237	11/04/16 - 11/08/16	11/21/16	0.00	2,569.00	0.00	0.00	0.00
615	2016344048991	11/15/16 - 11/23/16	12/19/16	0.00	2,569.00	0.00	0.00	0.00
615	2016364069939	12/15/16 - 12/22/16	01/02/17	0.00	8,530.00	0.00	0.00	0.00
615	2017027074464	01/20/17 - 01/22/17	02/06/17	0.00	2,569.00	0.00	0.00	0.00
615	2017036001115	01/30/17 - 01/31/17	02/13/17	0.00	8,530.00	0.00	0.00	0.00
615	2017042028319	02/04/17 - 02/06/17	02/20/17	0.00	2,569.00	0.00	0.00	0.00
615	2017068096267	02/13/17 - 03/04/17	03/13/17	0.00	4,265.00	0.00	0.00	0.00
615	2017069075634	03/01/17 - 03/05/17	03/20/17	0.00	4,265.00	0.00	0.00	0.00
615	2017075084218	03/09/17 - 03/11/17	03/20/17	0.00	8,530.00	0.00	0.00	0.00
615	2017076070221	02/19/17 - 03/07/17	03/27/17	0.00	8,530.00	0.00	0.00	0.00
614	2217079006993	09/11/16 - 09/26/16	03/27/17	0.00	8,530.00	0.00	0.00	0.00
615	2017088083497	03/19/17 - 03/22/17	04/03/17	0.00	8,530.00	0.00	0.00	0.00
615	2017089079076	03/22/17 - 03/25/17	04/03/17	0.00	2,569.00	0.00	0.00	0.00
614	2217093007007	12/02/16 - 12/15/16	04/10/17	0.00	5,138.00	0.00	0.00	0.00
614	2217095011720	02/26/17 - 03/19/17	04/10/17	0.00	4,265.00	0.00	0.00	0.00
615	2017096088944	03/29/17 - 03/31/17	04/10/17	0.00	4,265.00	0.00	0.00	0.00
614	2017104076813	12/04/16 - 01/20/17	04/24/17	0.00	4,265.00	0.00	0.00	0.00
615	2017129077792	04/11/17 - 04/22/17	05/29/17	0.00	6,834.00	0.00	0.00	0.00
615	2017139126237	12/19/16 - 12/28/16	05/29/17	0.00	2,569.00	0.00	0.00	0.00
615	2017148002044	05/13/17 - 05/23/17	06/05/17	0.00	2,569.00	0.00	0.00	0.00
615	2017160086987	05/13/17 - 05/19/17	06/19/17	0.00	8,530.00	0.00	0.00	0.00
615	2017181028911	06/23/17 - 06/25/17	07/17/17	0.00	2,569.00	0.00	0.00	0.00
615	2017188075285	06/25/17 - 06/29/17	07/17/17	0.00	2,569.00	0.00	0.00	0.00
615	2017194078527	06/23/17 - 07/05/17	07/17/17	0.00	4,265.00	0.00	0.00	0.00
614	5217198000254	03/10/17 - 03/27/17	07/24/17	0.00	2,569.00	0.00	0.00	0.00
615	2017199079689	07/11/17 - 07/12/17	07/24/17	0.00	4,265.00	0.00	0.00	0.00
614	2317215000151	11/02/16 - 12/08/16	09/11/17	0.00	4,265.00	0.00	2,787.65	0.00
615	2017228069027	07/28/17 - 08/11/17	08/21/17	0.00	2,569.00	0.00	0.00	0.00
615	2217234004930	06/22/17 - 07/04/17	08/28/17	0.00	2,569.00	0.00	0.00	0.00
615	2017244089149	08/15/17 - 08/25/17	09/11/17	0.00	8,530.00	0.00	0.00	0.00
615	2317282000137	05/08/17 - 05/16/17	11/13/17	0.00	2,569.00	0.00	2,660.90	0.00
615	5217292000335	06/14/17 - 09/01/17	10/23/17	0.00	8,530.00	0.00	0.00	0.00
615	2317305000049	03/17/17 - 03/26/17	11/06/17	0.00	4,265.00	0.00	0.00	0.00
614	2317321000213	11/06/16 - 11/08/16	12/18/17	0.00	4,265.00	0.00	901.26	0.00
615	2317349000087	05/20/17 - 06/07/17	12/25/17	0.00	2,569.00	0.00	0.00	0.00
614	5218020000001	05/26/17 - 11/07/17	01/29/18	0.00	8,530.00	0.00	0.00	0.00
615	5218020000001	05/26/17 - 11/07/17	01/29/18	0.00	4,265.00	0.00	0.00	0.00
614	2318022000181	08/11/17 - 08/16/17	02/05/18	0.00	4,265.00	0.00	1,316.43	0.00
615	2018023058439	05/12/17 - 05/26/17	01/29/18	0.00	2,569.00	0.00	0.00	0.00
615	9718067981010	09/28/16 - 10/07/16	03/12/18	0.00	8,530.00	0.00	3,086.47	0.00

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

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

Run Date: 08/29/2018
Run Time: 00:18:08
Page: 4

EMORY UNIVERSITY HOSPITAL MIDTOWN		PROVIDER NUMBER	PAYMENT DATES		00/00/00	THROUGH	00/00/00	
550 PEACHTREE ST NE		000000503A	SERVICE DATES		09/01/16	THROUGH	08/31/17	
ATLANTA,GA 30308-2247			ADMISSION DATES		00/00/00	THROUGH	00/00/00	
614	2318072000122	02/27/17 - 03/01/17	03/26/18	0.00	2,569.00	0.00	292.10	0.00
614	2018142084111	09/01/16 - 09/15/16	05/28/18	0.00	4,414.00	0.00	0.00	0.00
TOTAL				0.00	219,560.00	0.00	11,044.81	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: 08/29/2018
 Run Time: 00:18:21
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	483,099.03	ADJUSTMENTS	0.00
COVERED CHARGES	475,080.91	CONTRACTUAL ALLOW	195,177.57
NON-COVERD CHARGES	8,018.12	TOTAL MEDICAID LIAB	279,903.34
		LESS: COB	279,903.34
		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	54		0	76,950.00		1,944.00
ROUTINE NURSERY	14		0	21,522.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	68		0	98,472.00		1,944.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	17,550.00		0.00
NICU	4		0	15,096.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7		0	32,646.00		0.00
TOTAL ACCOMODATIONS	75		0	131,118.00		1,944.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,911.91	0.00	OTHER LAB	1,782.00	0.00
MED/SURG SUPPLY	22,939.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	66,196.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,013.00	0.00	OTHER THERAPEUTIC SVC	0.00	5,030.00
CT SCAN	2,882.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,177.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,314.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,259.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,052.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,952.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,819.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,502.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,004.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,289.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,044.12
LABORATORY PATHOLOGIC	5,467.00	0.00	INJECTABLE DRUGS	22,744.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	464.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,776.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	764.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,681.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,974.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	343,962.91	6,074.12
			TOTAL ACCOMODATIONS	131,118.00	1,944.00
			TOTAL CHARGES	475,080.91	8,018.12

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: 08/29/2018
Run Time: 00:18:23
Page: 7

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,020,149.02	ADJUSTMENTS	464,816.26
COVERED CHARGES	25,676,504.41	CONTRACTUAL ALLOW	19,469,610.43
NON-COVERD CHARGES	8,343,644.61	TOTAL MEDICAID LIAB	6,206,893.98
		LESS: COB	13,878.24
		LESS: COPAYMENT	18,442.76
		REIMBURSEMENT	6,174,572.98
		ALL OTHER	3,979,048.72
		FEE SCHEDULE-LAB	555,247.18
		INJECTABLE DRUGS	1,640,277.08
		TOTAL NUMBER OF CLAIMS	10,874

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352,844.82	499,387.22	OTHER LAB	295,335.00	2,200.00
MED/SURG SUPPLY	594,003.92	29,063.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,371.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	850,180.00	126,668.00	OTHER THERAPEUTIC SVC	2,515.00	160,323.00
CT SCAN	2,003,439.00	1,158,161.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	392.00	22,694.13	FEE SCHEDULE LAB	5,428,223.00	425,151.00
EKG/ECG	288,934.00	8,760.00	MRI SERVICES	635,334.00	619,485.00
IV THERAPY	1,132,967.00	19,025.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,977,418.00	584,844.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,193.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157,366.34	78,351.41	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	425,322.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	113,306.00	117,916.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,167,868.00	87,039.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	517,433.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	41.76
LABORATORY PATHOLOGIC	0.00	248.00	INJECTABLE DRUGS	2,518,189.73	1,832,549.41
RADIOLOGY THERAPEUTIC	344,631.00	46,618.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	7,893.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	657.00	9,653.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	245,120.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89,327.00	18,251.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	63,874.60	341,424.54
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	84,477.00
OTHER IMAGING SERVICE	826,966.00	827,842.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	882,648.50	118,670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	371,841.00	460,412.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	660,841.00	305,175.00			
AMBULATORY SURGERY	953.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,673.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	930,828.50	103,831.00			
			TOTAL ANCILLARY	25,676,504.41	8,343,644.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,676,504.41	8,343,644.61

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016278060275	09/22/16 - 09/22/16	10/10/16	0.00	4,265.00	0.00	0.00	0.00
615	2016278060275	09/22/16 - 09/22/16	10/10/16	0.00	4,265.00	0.00	0.00	0.00
615	2016299051478	10/18/16 - 10/18/16	10/31/16	0.00	4,265.00	0.00	0.00	0.00
615	2016299051478	10/18/16 - 10/18/16	10/31/16	0.00	4,265.00	0.00	0.00	0.00
615	2016299052319	10/18/16 - 10/18/16	10/31/16	0.00	4,265.00	0.00	0.00	0.00
615	2016299052319	10/18/16 - 10/18/16	10/31/16	0.00	4,265.00	0.00	0.00	0.00
615	2016299052319	10/18/16 - 10/18/16	10/31/16	0.00	4,265.00	0.00	0.00	0.00
615	2216301001753	09/27/16 - 09/27/16	10/31/16	0.00	4,265.00	0.00	0.00	0.00
615	2216301001753	09/27/16 - 09/27/16	10/31/16	0.00	4,265.00	0.00	0.00	0.00
615	2216308013027	09/15/16 - 09/15/16	11/07/16	0.00	2,569.00	0.00	0.00	0.00
615	2016319030603	11/02/16 - 11/02/16	11/21/16	0.00	4,265.00	0.00	0.00	0.00
615	2016319030603	11/02/16 - 11/02/16	11/21/16	0.00	4,265.00	0.00	0.00	0.00
615	2016327087990	11/17/16 - 11/17/16	11/28/16	0.00	4,265.00	0.00	0.00	0.00
615	2016356063872	12/15/16 - 12/15/16	12/26/16	0.00	4,265.00	0.00	0.00	0.00
615	2017025082228	01/20/17 - 01/20/17	01/30/17	0.00	4,265.00	0.00	0.00	0.00
615	2017103079047	04/06/17 - 04/06/17	04/17/17	0.00	4,265.00	0.00	0.00	0.00
615	2017103079047	04/06/17 - 04/06/17	04/17/17	0.00	4,265.00	0.00	0.00	0.00
615	2017208076786	07/18/17 - 07/18/17	07/31/17	0.00	4,265.00	0.00	0.00	0.00
615	2017214071497	07/27/17 - 07/27/17	08/07/17	0.00	2,569.00	0.00	0.00	0.00
615	2017234054131	08/16/17 - 08/16/17	08/28/17	0.00	2,569.00	0.00	0.00	0.00
615	2017234054131	08/16/17 - 08/16/17	08/28/17	0.00	4,265.00	0.00	0.00	0.00
615	2217236012503	07/05/17 - 07/05/17	08/28/17	0.00	4,265.00	0.00	0.00	0.00
TOTAL				0.00	84,477.00	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: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	784,655.13	ADJUSTMENTS	0.00
COVERED CHARGES	381,011.44	CONTRACTUAL ALLOW	40,410.26
NON-COVERD CHARGES	403,643.69	TOTAL MEDICAID LIAB	340,601.18
		LESS: COB	340,212.97
		LESS: COPAYMENT	388.21
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 199

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

EMORY UNIVERSITY HOSPITAL MIDTOWN PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 550 PEACHTREE ST NE 000000503A SERVICE DATES 09/01/16 THROUGH 08/31/17
 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	10,741.95	6,350.36	OTHER LAB	6,237.00	0.00
MED/SURG SUPPLY	13,040.00	25.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,142.00	2,141.00	OTHER THERAPEUTIC SVC	0.00	438.00
CT SCAN	0.00	22,843.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	974.03	FEE SCHEDULE LAB	91,234.00	18,334.00
EKG/ECG	2,555.00	146.00	MRI SERVICES	0.00	42,650.00
IV THERAPY	21,954.00	1,396.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,114.00	37,588.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,115.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,032.00	820.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,280.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,590.00	324.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,675.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	18,022.40
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,011.99	189,344.84
RADIOLOGY THERAPEUTIC	10,240.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,109.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	657.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	493.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,077.00	1,819.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	11,099.00
OTHER IMAGING SERVICE	7,056.00	4,334.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,718.50	1,899.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,773.00	10,467.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,248.00	12,858.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,177.00	17,512.00			
			TOTAL ANCILLARY	381,011.44	403,643.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	381,011.44	403,643.69

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 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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017186208964	05/25/17 - 05/25/17	07/10/17	0.00	4,265.00	0.00	14,202.45	0.00
615	2017186208964	05/25/17 - 05/25/17	07/10/17	0.00	4,265.00	0.00	14,202.45	0.00
614	2017304062670	01/27/17 - 01/27/17	11/06/17	0.00	2,569.00	0.00	983.28	0.00
TOTAL				0.00	11,099.00	0.00	29,388.18	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: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	330,684.63	ADJUSTMENTS	270.39
COVERED CHARGES	308,096.04	CONTRACTUAL ALLOW	291,873.44
NON-COVERD CHARGES	22,588.59	TOTAL MEDICAID LIAB	16,222.60
		LESS: COB	0.00
		LESS: COPAYMENT	757.66
		REIMBURSEMENT	15,464.94
		TOTAL NUMBER OF CLAIMS	290

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.37	2,545.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,527.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,931.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,766.00	12,694.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	68,270.00	1,790.00
EKG/ECG	4,672.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	445.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	840.00	234.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	165,856.00	1,907.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,025.67	181.79
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	82.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,808.00	926.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,859.00	2,228.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,930.00	0.00			
			TOTAL ANCILLARY	308,096.04	22,588.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	308,096.04	22,588.59

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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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,384.73	ADJUSTMENTS	0.00
COVERED CHARGES	3,292.42	CONTRACTUAL ALLOW	2,218.90
NON-COVERD CHARGES	92.31	TOTAL MEDICAID LIAB	1,073.52
		LESS: COB	1,070.52
		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

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 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	7.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	338.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	558.00	0.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,214.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29.42	92.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,292.42	92.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,292.42	92.31

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,836,290.67	ADJUSTMENTS	190,278.23
COVERED CHARGES	3,554,131.61	CONTRACTUAL ALLOW	2,516,981.74
NON-COVERD CHARGES	282,159.06	TOTAL MEDICAID LIAB	1,037,149.87
		LESS: COB	0.00
		LESS: COPAYMENT	1,471.90
		REIMBURSEMENT	1,035,677.97

TOTAL NUMBER OF CLAIMS 169

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,875.38	1,255.78	OTHER LAB	637.00	891.00
MED/SURG SUPPLY	147,230.99	1,855.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,554.00	10,551.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	582.00	FEE SCHEDULE LAB	258,735.00	10,435.00
EKG/ECG	1,460.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	308,553.00	8,374.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	617,468.00	609.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,193.00	387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	110,187.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	69,450.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,496,142.17	130,187.26
RADIOLOGY THERAPEUTIC	71,804.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	657.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	20,212.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	194,978.07	47,842.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	98.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,316.00	14,665.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	600.00	2,238.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	134,067.00	26,582.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,783.00	4,836.00			
			TOTAL ANCILLARY	3,554,131.61	282,159.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,554,131.61	282,159.06

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA,GA 30308-2247

PROVIDER NUMBER
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	232,470.76	ADJUSTMENTS	0.00
COVERED CHARGES	197,247.56	CONTRACTUAL ALLOW	44,219.52
NON-COVERD CHARGES	35,223.20	TOTAL MEDICAID LIAB	153,028.04
		LESS: COB	152,968.04
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	480.00	210.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	531.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,872.00	575.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,502.00	186.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	168,898.56	33,595.20
RADIOLOGY THERAPEUTIC	13,380.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	146.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	438.00	657.00			
			TOTAL ANCILLARY	197,247.56	35,223.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	197,247.56	35,223.20

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,780,265.12	ADJUSTMENTS	153,869.77
COVERED CHARGES	5,658,598.68	CONTRACTUAL ALLOW	3,422,480.80
NON-COVERD CHARGES	121,666.44	TOTAL MEDICAID LIAB	2,236,117.88
		LESS: COB	26,372.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,209,745.79

TOTAL NUMBER OF ADMISSIONS 248

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	708		0	506,688.00		22,513.00
ROUTINE NURSERY	60		0	43,200.00		19,420.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		20.00
TOTAL ROUTINE	768		0	549,888.00		41,953.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	380		0	585,200.00		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	380		0	585,200.00		0.00
TOTAL ACCOMODATIONS	1,148		0	1,135,088.00		41,953.00

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	351,209.28	0.00	OTHER LAB	17,689.00	0.00
MED/SURG SUPPLY	421,135.07	666.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	875,420.90	0.00	EDUCATION & TRAINING	11,505.00	0.00
RADIOLOGY-DIAGNOSTIC	105,520.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	336,268.00	8,443.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	63,072.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	37,488.00	0.00	MRI SERVICES	22,531.00	0.00
IV THERAPY	114,828.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	432,252.65	6,288.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,669.66	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	453,924.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,620.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	168,412.37	0.00	SPECIAL SERVICES	0.00	10,720.00
RECOVERY ROOM	32,517.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	13,359.28	0.00	INJECTABLE DRUGS	475,357.97	0.00
RADIOLOGY THERAPEUTIC	318.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	29,844.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,409.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	24,210.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,409.26	3,253.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	218,051.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,510.00
OTHER IMAGING SERVICE	29,559.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63,988.00	42,253.44			
ONCOLOGY	119.00	0.00			
NUCLEAR MEDICINE	6,463.00	1,125.00			
AUDIOLOGY	5,729.04	0.00			
CARDIOLOGY	81,007.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,036.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,589.00	455.00			
			TOTAL ANCILLARY	4,523,510.68	79,713.44
			TOTAL ACCOMODATIONS	1,135,088.00	41,953.00
			TOTAL CHARGES	5,658,598.68	121,666.44

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	2317020000228	07/01/16 - 07/08/16	02/27/17	0.00	6,510.00	0.00	1,031.52	0.00
TOTAL				0.00	6,510.00	0.00	1,031.52	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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,073.96	ADJUSTMENTS	0.00
COVERED CHARGES	23,783.96	CONTRACTUAL ALLOW	4,888.03
NON-COVERD CHARGES	290.00	TOTAL MEDICAID LIAB	18,895.93
		LESS: COB	18,895.93
		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	2,880.00		0.00
ROUTINE NURSERY	1		0	720.00		290.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	3,600.00		290.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	3,600.00		290.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,264.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,557.71	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,145.66	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	453.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,682.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	820.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,896.72	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	588.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	62.07	0.00	INJECTABLE DRUGS	1,392.54	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	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	1,981.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	238.71	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,183.96	0.00
			TOTAL ACCOMODATIONS	3,600.00	290.00
			TOTAL CHARGES	23,783.96	290.00

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,689,569.19	ADJUSTMENTS	267,213.43
COVERED CHARGES	6,059,275.97	CONTRACTUAL ALLOW	4,779,824.26
NON-COVERD CHARGES	630,293.22	TOTAL MEDICAID LIAB	1,279,451.71
		LESS: COB	484.29
		LESS: COPAYMENT	4,747.46
		REIMBURSEMENT	1,274,219.96
		ALL OTHER	944,308.24
		FEE SCHEDULE-LAB	180,148.05
		INJECTABLE DRUGS	149,763.67
		TOTAL NUMBER OF CLAIMS	4,243

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,249.73	43,604.73	OTHER LAB	125,433.60	1,564.00
MED/SURG SUPPLY	163,106.52	11,595.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	396.00	EDUCATION & TRAINING	0.00	472.00
RADIOLOGY-DIAGNOSTIC	262,640.66	15,915.23	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,015,939.00	117,003.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,006.00	4,433.00	FEE SCHEDULE LAB	1,582,708.69	70,792.31
EKG/ECG	75,524.00	1,278.00	MRI SERVICES	138,570.00	2,394.00
IV THERAPY	192,897.77	25,198.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	468,851.36	110,778.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,096.62	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,125.23	15,680.23	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	75,890.00	400.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	759,249.83	12,735.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,311.00	588.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	437,943.30	89,349.52
RADIOLOGY THERAPEUTIC	28,559.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	401.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,735.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,842.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	55,144.79	13,128.50	TRAUMA RESPONSE	0.00	3,320.52
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,034.97	16,892.39
LITHOTRIPSY	34,251.00	0.00	NO CC/INVALID REV CODE	0.00	113.00
OTHER IMAGING SERVICE	142,977.00	16,747.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,926.00	3,177.16			
ONCOLOGY	10,442.00	1,205.00			
NUCLEAR MEDICINE	119,623.00	31,405.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	71,869.00	10,003.00			
AMBULATORY SURGERY	1,298.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,527.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	83,080.90	2,146.00			
			TOTAL ANCILLARY	6,059,275.97	630,293.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,059,275.97	630,293.22

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

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8237	5917303000476	07/26/16 - 07/26/16	11/06/17	0.00	113.00	0.00	0.00	0.00
TOTAL				0.00	113.00	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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,607.54	ADJUSTMENTS	0.00
COVERED CHARGES	84,699.56	CONTRACTUAL ALLOW	14,425.55
NON-COVERD CHARGES	16,907.98	TOTAL MEDICAID LIAB	70,274.01
		LESS: COB	70,258.68
		LESS: COPAYMENT	15.33
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 71

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	591.68	458.76	OTHER LAB	616.00	0.00
MED/SURG SUPPLY	2,208.05	65.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,526.00	640.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,680.00	10,045.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,764.71	1,157.00
EKG/ECG	426.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,852.00	1,344.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,052.00	1,741.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	787.54	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,209.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	940.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,534.04	326.00	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	2,116.54	94.22
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	531.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	287.00	221.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	399.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,957.00	285.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,165.00	0.00			
			TOTAL ANCILLARY	84,699.56	16,907.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	84,699.56	16,907.98

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	195,712.86	ADJUSTMENTS	355.58
COVERED CHARGES	185,941.43	CONTRACTUAL ALLOW	173,354.93
NON-COVERD CHARGES	9,771.43	TOTAL MEDICAID LIAB	12,586.50
		LESS: COB	21.00
		LESS: COPAYMENT	453.35
		REIMBURSEMENT	12,112.15
		TOTAL NUMBER OF CLAIMS	225

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,166.53	671.38	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,664.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,518.00	1,447.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,771.00	5,710.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,126.66	1,167.00
EKG/ECG	3,408.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,083.00	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	1,116.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,074.10	336.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,385.14	440.05
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	102.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	266.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,261.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	185,941.43	9,771.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	185,941.43	9,771.43

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,431.10	ADJUSTMENTS	0.00
COVERED CHARGES	2,415.10	CONTRACTUAL ALLOW	1,969.92
NON-COVERD CHARGES	16.00	TOTAL MEDICAID LIAB	445.18
		LESS: COB	445.18
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	1,754.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	647.10	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	2,415.10	16.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,415.10	16.00

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	319,254.56	ADJUSTMENTS	0.00
COVERED CHARGES	291,065.65	CONTRACTUAL ALLOW	198,993.81
NON-COVERD CHARGES	28,188.91	TOTAL MEDICAID LIAB	92,071.84
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	91,999.84
		TOTAL NUMBER OF CLAIMS	16

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	608.73	280.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,761.77	42.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	192.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,795.66	672.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,633.00	5,277.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,437.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	404.51	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,800.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	588.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	240,787.48	21,463.23
RADIOLOGY THERAPEUTIC	7,467.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	868.00	453.88			
ONCOLOGY	408.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,314.00	0.00			
			TOTAL ANCILLARY	291,065.65	28,188.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	291,065.65	28,188.91

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,059.73	ADJUSTMENTS	0.00
COVERED CHARGES	25,856.91	CONTRACTUAL ALLOW	9,263.72
NON-COVERD CHARGES	202.82	TOTAL MEDICAID LIAB	16,593.19
		LESS: COB	16,580.74
		LESS: COPAYMENT	12.45
		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: 08/29/2018
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSPITAL
 902 N 7TH ST
 CORDELE,GA 31015-3234

PROVIDER NUMBER
 000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212.80	58.04	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	370.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,118.00	32.00
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	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	22,294.11	112.78
RADIOLOGY THERAPEUTIC	827.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	336.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,856.91	202.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,856.91	202.82

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,055,342.90	ADJUSTMENTS	124,601.77
COVERED CHARGES	2,424,088.70	CONTRACTUAL ALLOW	1,872,855.49
NON-COVERD CHARGES	631,254.20	TOTAL MEDICAID LIAB	551,233.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	551,233.21

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	468		0	448,344.00		620,100.00
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	468		0	448,344.00		620,100.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	96		0	256,195.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	96		0	256,195.00		0.00
TOTAL ACCOMODATIONS	564		0	704,539.00		620,100.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,714.80	0.00	OTHER LAB	2,364.00	0.00
MED/SURG SUPPLY	205,853.19	2,528.08	RECREATIONAL THERAPY	2,204.00	0.00
LABORATORY-GENERAL	201,112.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,408.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,991.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,269.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,634.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,646.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	675,225.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	437.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,997.00	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	2,045.00	0.00	INJECTABLE DRUGS	175,670.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	32,236.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,309.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	158.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,871.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,636.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,398.00	7,568.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,992.00	1,058.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,190.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,722.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,466.32	0.00			
			TOTAL ANCILLARY	1,719,549.70	11,154.20
			TOTAL ACCOMODATIONS	704,539.00	620,100.00
			TOTAL CHARGES	2,424,088.70	631,254.20

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

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

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

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

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DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

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

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DECATUR HLTH RESOURCES INCHOSP
450 N CANDLER ST
DECATUR,GA 30030-2626

PROVIDER NUMBER
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
 2701 N DECATUR RD
 DECATUR,GA 30033-5918

PROVIDER NUMBER 000000536A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,831,603.61	ADJUSTMENTS	1,117,978.58
COVERED CHARGES	45,656,298.59	CONTRACTUAL ALLOW	29,323,564.63
NON-COVERD CHARGES	3,175,305.02	TOTAL MEDICAID LIAB	16,332,733.96
		LESS: COB	213,471.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,119,262.66

TOTAL NUMBER OF ADMISSIONS 2,317

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,227		0	5,962,878.00		1,723,052.10
ROUTINE NURSERY	1,987		0	2,747,262.00		634,010.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,214		0	8,710,140.00		2,357,062.10
SPECIAL CARE SERVICES						
CCU	8		0	10,478.00		0.00
ICU	1,154		0	2,930,512.00		0.00
NICU	142		0	460,506.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		7	0.00		16,568.00
REHAB	0		226	0.00		289,280.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,304		233	3,401,496.00		305,848.00
TOTAL ACCOMODATIONS	9,518		233	12,111,636.00		2,662,910.10

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,180,168.06	505.30	OTHER LAB	416,346.90	0.00
MED/SURG SUPPLY	967,718.91	10,163.02	RECREATIONAL THERAPY	31,624.00	0.00
LABORATORY-GENERAL	5,236,609.00	7,766.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	779,520.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,261,313.00	53,280.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	742,384.67	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	346,299.00	0.00	MRI SERVICES	303,655.00	0.00
IV THERAPY	770,569.17	12,983.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,377,587.00	16,005.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	638,870.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,176,251.89	2,181.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	569,628.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	93,523.00	2,937.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,759,320.81	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,344,994.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	198,766.00	0.00	INJECTABLE DRUGS	3,544,775.01	41.60
RADIOLOGY THERAPEUTIC	66,933.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	450,472.34	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	346,530.41	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	251,516.00	6,356.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	52,535.00	1,231.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,540.00	0.00	IMPL DEV CHARGE PATIENTS	828,468.22	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,281.00
OTHER IMAGING SERVICE	357,110.68	4,862.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	288,846.00	328,368.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	260,047.00	62,147.00			
AUDIOLOGY	129,384.50	0.00			
CARDIOLOGY	1,234,349.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	62,606.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	473,401.02	288.00			
			TOTAL ANCILLARY	33,544,662.59	512,394.92
			TOTAL ACCOMODATIONS	12,111,636.00	2,662,910.10
			TOTAL CHARGES	45,656,298.59	3,175,305.02

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017094074475	03/28/17 - 03/30/17	04/10/17	0.00	386.00	0.00	0.00	0.00
948	2017109073774	04/05/17 - 04/07/17	04/24/17	0.00	386.00	0.00	0.00	0.00
-1	2317114000059	02/14/17 - 02/18/17	06/05/17	0.00	193.00	0.00	1,943.04	0.00
948	2217116003812	03/09/17 - 03/11/17	05/01/17	0.00	386.00	0.00	0.00	0.00
948	2217137004455	03/22/17 - 03/23/17	05/22/17	0.00	386.00	0.00	0.00	0.00
948	2017146070360	05/08/17 - 05/08/17	06/05/17	0.00	193.00	0.00	0.00	0.00
948	2217167002730	06/02/17 - 06/03/17	06/19/17	0.00	193.00	0.00	0.00	0.00
948	2217170005204	04/04/17 - 04/08/17	06/26/17	0.00	193.00	0.00	0.00	0.00
948	2017171000416	06/08/17 - 06/13/17	06/26/17	0.00	193.00	0.00	0.00	0.00
948	2017178059740	05/02/17 - 05/04/17	07/03/17	0.00	193.00	0.00	0.00	0.00
948	2217208003459	06/12/17 - 06/15/17	07/31/17	0.00	193.00	0.00	0.00	0.00
-1	2317212000066	04/24/17 - 04/27/17	09/04/17	0.00	386.00	0.00	1,016.93	0.00
TOTAL				0.00	3,281.00	0.00	2,959.97	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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	816,686.24	ADJUSTMENTS	0.00
COVERED CHARGES	792,802.24	CONTRACTUAL ALLOW	334,487.62
NON-COVERD CHARGES	23,884.00	TOTAL MEDICAID LIAB	458,314.62
		LESS: COB	458,314.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	84		1	80,472.00		14,288.00
ROUTINE NURSERY	18		0	28,344.00		4,840.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	102		1	108,816.00		19,128.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	8,192.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	8,192.00		0.00
TOTAL ACCOMODATIONS	106		1	117,008.00		19,128.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,685.50	0.00	OTHER LAB	5,089.00	0.00
MED/SURG SUPPLY	7,335.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	46,537.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,025.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,160.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,211.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,878.00	0.00	MRI SERVICES	1,591.00	0.00
IV THERAPY	9,213.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,844.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,881.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,092.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,726.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,104.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,164.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	329.00	0.00	INJECTABLE DRUGS	327,440.96	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	607.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	448.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	316.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,234.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,771.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,395.00	4,756.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,482.00	0.00			
CARDIOLOGY	1,242.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,992.00	0.00			
			TOTAL ANCILLARY	675,794.24	4,756.00
			TOTAL ACCOMODATIONS	117,008.00	19,128.00
			TOTAL CHARGES	792,802.24	23,884.00

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,636,048.81	ADJUSTMENTS	537,271.16
COVERED CHARGES	18,813,366.00	CONTRACTUAL ALLOW	15,499,973.58
NON-COVERD CHARGES	1,822,682.81	TOTAL MEDICAID LIAB	3,313,392.42
		LESS: COB	2,273.65
		LESS: COPAYMENT	7,462.15
		REIMBURSEMENT	3,303,656.62
		ALL OTHER	2,910,578.85
		FEE SCHEDULE-LAB	244,620.41
		INJECTABLE DRUGS	148,457.36
		TOTAL NUMBER OF CLAIMS	6,560

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	314,956.38	736.30	OTHER LAB	346,781.00	2,394.00
MED/SURG SUPPLY	268,165.18	44,561.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	982,826.00	49,978.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,530,926.00	191,523.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	117,437.00	46,546.11	FEE SCHEDULE LAB	2,817,380.95	166,017.85
EKG/ECG	419,118.00	2,504.00	MRI SERVICES	259,890.00	54,333.00
IV THERAPY	1,113,018.00	20,468.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,072,615.91	276,845.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	187,904.00	54,744.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	360,855.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	45,597.50	16,588.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,127,459.00	8,206.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	518,083.00	1,863.00	DRUG-SPECIFIC/HOME IV	0.00	6,747.20
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	697,568.20	194,550.90
RADIOLOGY THERAPEUTIC	277,354.00	59,130.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,795.00	18,173.51	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,034.00	10,441.43	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	30,872.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,544.00	11,460.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	87,800.02	78,476.52
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	918,931.00	122,621.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,472.00	22,396.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	214,068.00	146,890.00			
AUDIOLOGY	4,790.00	1,843.00			
CARDIOLOGY	271,760.00	102,556.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,938.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	734,298.86	79,217.05			
			TOTAL ANCILLARY	18,813,366.00	1,822,682.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,813,366.00	1,822,682.81

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	341,280.95	ADJUSTMENTS	0.00
COVERED CHARGES	239,102.57	CONTRACTUAL ALLOW	131,164.88
NON-COVERD CHARGES	102,178.38	TOTAL MEDICAID LIAB	107,937.69
		LESS: COB	107,862.69
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 90

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,525.70	118.20	OTHER LAB	9,124.00	1,596.00
MED/SURG SUPPLY	2,969.42	6,807.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,157.00	540.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,791.00	12,050.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,659.15	1,399.00
EKG/ECG	3,130.00	0.00	MRI SERVICES	2,395.00	3,776.00
IV THERAPY	8,741.00	2,038.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,421.00	38,532.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	903.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,496.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,946.00	643.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,691.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,977.30	6,606.20
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	647.00	79.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	11,766.85
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,456.00	10,201.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,185.00	4,783.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	931.00	1,242.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,361.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,596.00	0.00			
			TOTAL ANCILLARY	239,102.57	102,178.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	239,102.57	102,178.38

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

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

Run Date: 08/29/2018
Run Time: 00:17:54
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	895,146.03	ADJUSTMENTS	379.58
COVERED CHARGES	876,113.23	CONTRACTUAL ALLOW	847,192.25
NON-COVERD CHARGES	19,032.80	TOTAL MEDICAID LIAB	28,920.98
		LESS: COB	0.00
		LESS: COPAYMENT	947.95
		REIMBURSEMENT	27,973.03
		TOTAL NUMBER OF CLAIMS	517

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,764.80	0.00	OTHER LAB	11,712.00	0.00
MED/SURG SUPPLY	1,525.13	429.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,515.00	1,532.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,121.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	176,258.90	7,158.00
EKG/ECG	12,207.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	61,204.00	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	2,479.00	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	485,365.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,673.80	563.80
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	384.60	843.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,370.00	8,308.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,068.00	199.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,465.00	0.00			
			TOTAL ANCILLARY	876,113.23	19,032.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	876,113.23	19,032.80

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,039.70	ADJUSTMENTS	0.00
COVERED CHARGES	29,220.70	CONTRACTUAL ALLOW	14,728.19
NON-COVERD CHARGES	6,819.00	TOTAL MEDICAID LIAB	14,492.51
		LESS: COB	14,486.51
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	309.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	234.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,320.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,144.00	170.00
EKG/ECG	313.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,354.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,011.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	440.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,348.00	4,329.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,048.00	0.00			
			TOTAL ANCILLARY	29,220.70	6,819.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,220.70	6,819.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,903,741.98	ADJUSTMENTS	78,668.20
COVERED CHARGES	1,743,329.01	CONTRACTUAL ALLOW	1,518,237.01
NON-COVERD CHARGES	160,412.97	TOTAL MEDICAID LIAB	225,092.00
		LESS: COB	0.00
		LESS: COPAYMENT	519.00
		REIMBURSEMENT	224,573.00
		TOTAL NUMBER OF CLAIMS	40

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,726.00	0.00	OTHER LAB	1,099.00	0.00
MED/SURG SUPPLY	36,511.46	10,020.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,671.00	2,320.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,203.00	944.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,408.03	FEE SCHEDULE LAB	47,489.00	938.00
EKG/ECG	8,138.00	313.00	MRI SERVICES	0.00	0.00
IV THERAPY	62,185.00	1,372.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	332,966.67	10,789.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,400.00	374.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,654.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,368.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,013.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	406,145.30	24,953.10
RADIOLOGY THERAPEUTIC	145,211.00	1,083.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	454.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,104.00	2,049.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	326,969.58	79,721.23
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,438.00	4,862.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	872.00	1,189.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,703.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	223,940.00	15,920.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,225.00	0.00			
			TOTAL ANCILLARY	1,743,329.01	160,412.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,743,329.01	160,412.97

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

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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:48:18
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,736,883.01	ADJUSTMENTS	392,106.26
COVERED CHARGES	12,879,198.13	CONTRACTUAL ALLOW	7,890,553.42
NON-COVERD CHARGES	857,684.88	TOTAL MEDICAID LIAB	4,988,644.71
		LESS: COB	39,751.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,948,892.80

TOTAL NUMBER OF ADMISSIONS 564

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,237		0	2,143,046.00		598,419.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,237		0	2,143,046.00		598,419.00
SPECIAL CARE SERVICES						
CCU	8		0	10,688.00		0.00
ICU	353		0	965,488.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	361		0	976,176.00		0.00
TOTAL ACCOMODATIONS	2,598		0	3,119,222.00		598,419.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
 2801 DEKALB MEDICAL PKWY
 LITHONIA,GA 30058-4996

PROVIDER NUMBER
 000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,048,504.94	25.70	OTHER LAB	100,344.00	0.00
MED/SURG SUPPLY	254,005.51	585.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,889,839.36	8,008.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	274,582.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	518,724.00	4,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	113,379.29	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	128,630.00	0.00	MRI SERVICES	86,205.00	0.00
IV THERAPY	442,502.14	1,804.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	508,946.62	36,930.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,136,220.00	774.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,004.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	39,862.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	985,228.51	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	83,268.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	32,665.99	1,315.00	INJECTABLE DRUGS	1,003,237.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	63,439.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	55,652.24	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	100,788.00	15,304.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,451.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	82,880.88	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	101,388.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	114,258.00	161,180.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	125,117.45	28,451.77			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	188,910.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,746.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	138,196.63	288.00			
			TOTAL ANCILLARY	9,759,976.13	259,265.88
			TOTAL ACCOMODATIONS	3,119,222.00	598,419.00
			TOTAL CHARGES	12,879,198.13	857,684.88

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,713.00	ADJUSTMENTS	0.00
COVERED CHARGES	87,629.00	CONTRACTUAL ALLOW	36,853.15
NON-COVERD CHARGES	2,084.00	TOTAL MEDICAID LIAB	50,775.85
		LESS: COB	50,775.85
		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	8		0	7,664.00		2,084.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	7,664.00		2,084.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	5,584.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,584.00		0.00
TOTAL ACCOMODATIONS	10		0	13,248.00		2,084.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE
 2801 DEKALB MEDICAL PKWY
 LITHONIA,GA 30058-4996

PROVIDER NUMBER
 000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,449.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	749.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,474.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	879.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,857.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	313.00	0.00	MRI SERVICES	1,497.00	0.00
IV THERAPY	1,918.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,755.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,368.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,427.20	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	908.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	343.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	719.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,724.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	74,381.00	0.00
			TOTAL ACCOMODATIONS	13,248.00	2,084.00
			TOTAL CHARGES	87,629.00	2,084.00

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

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

Run Date: 08/29/2018
Run Time: 00:48:22
Page: 5

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,100,808.82	ADJUSTMENTS	332,485.31
COVERED CHARGES	12,390,147.76	CONTRACTUAL ALLOW	10,122,069.11
NON-COVERD CHARGES	710,661.06	TOTAL MEDICAID LIAB	2,268,078.65
		LESS: COB	2,504.98
		LESS: COPAYMENT	3,432.00
		REIMBURSEMENT	2,262,141.67
		ALL OTHER	2,061,939.37
		FEE SCHEDULE-LAB	163,807.29
		INJECTABLE DRUGS	36,395.01

TOTAL NUMBER OF CLAIMS 4,899

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	230,813.91	481.00	OTHER LAB	164,481.00	2,799.00
MED/SURG SUPPLY	92,768.59	5,854.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	752,404.00	30,364.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,099,582.00	158,012.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	138,380.00	38,235.14	FEE SCHEDULE LAB	1,982,746.10	83,074.80
EKG/ECG	279,943.00	313.00	MRI SERVICES	140,348.00	27,224.00
IV THERAPY	981,571.00	9,484.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	397,775.67	59,868.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76,001.00	5,327.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,040.00	1,110.00	AMBULANCE	0.00	0.00
GI SERVICES	12,112.00	5,340.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,356,661.00	7,303.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	126,540.00	1,117.00	DRUG-SPECIFIC/HOME IV	0.00	2,811.30
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277,525.10	20,474.80
RADIOLOGY THERAPEUTIC	26,323.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,752.00	6,127.10	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,510.00	5,357.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	3,840.00	6,618.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,676.89	21,098.79
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	502,115.00	69,819.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,592.00	5,945.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	71,291.00	61,679.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	60,531.00	15,386.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,498.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	390,326.50	48,542.50			
			TOTAL ANCILLARY	12,390,147.76	710,661.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,390,147.76	710,661.06

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	227,178.07	ADJUSTMENTS	0.00
COVERED CHARGES	189,264.67	CONTRACTUAL ALLOW	88,490.44
NON-COVERD CHARGES	37,913.40	TOTAL MEDICAID LIAB	100,774.23
		LESS: COB	100,744.23
		LESS: COPAYMENT	30.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,361.10	0.00	OTHER LAB	933.00	0.00
MED/SURG SUPPLY	2,629.13	917.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,910.00	2,638.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,638.00	16,536.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	426.00	FEE SCHEDULE LAB	29,193.15	754.00
EKG/ECG	4,382.00	0.00	MRI SERVICES	1,591.00	5,307.00
IV THERAPY	14,585.00	180.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,260.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,342.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,984.00	487.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,630.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,707.60	575.40
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	79.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,754.69	3,780.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,258.00	4,898.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,185.00	94.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,242.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,361.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,560.00	0.00			
			TOTAL ANCILLARY	189,264.67	37,913.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	189,264.67	37,913.40

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,148,265.25	ADJUSTMENTS	326.64
COVERED CHARGES	1,120,379.85	CONTRACTUAL ALLOW	1,078,201.09
NON-COVERD CHARGES	27,885.40	TOTAL MEDICAID LIAB	42,178.76
		LESS: COB	0.00
		LESS: COPAYMENT	1,225.43
		REIMBURSEMENT	40,953.33
		TOTAL NUMBER OF CLAIMS	754

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,867.80	0.00	OTHER LAB	3,732.00	0.00
MED/SURG SUPPLY	132.00	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,287.00	2,395.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,068.00	6,960.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	198,667.75	5,686.00
EKG/ECG	13,459.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	84,606.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	772.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	663,712.00	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	23,331.30	392.40
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	44,617.00	12,322.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	128.00	0.00			
			TOTAL ANCILLARY	1,120,379.85	27,885.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,120,379.85	27,885.40

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,289.85	ADJUSTMENTS	0.00
COVERED CHARGES	28,201.85	CONTRACTUAL ALLOW	12,091.05
NON-COVERD CHARGES	4,088.00	TOTAL MEDICAID LIAB	16,110.80
		LESS: COB	16,077.80
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225.90	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,492.00	1,948.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,388.15	357.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,323.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,644.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	762.80	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	2,366.00	1,783.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,201.85	4,088.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,201.85	4,088.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,611.38	ADJUSTMENTS	5,793.13
COVERED CHARGES	84,290.08	CONTRACTUAL ALLOW	72,691.82
NON-COVERD CHARGES	4,321.30	TOTAL MEDICAID LIAB	11,598.26
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	11,586.26

TOTAL NUMBER OF CLAIMS 2

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	571.90	0.00	OTHER LAB	1,203.00	0.00
MED/SURG SUPPLY	4,927.88	1,120.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,320.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,464.00	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	58,040.00	1,922.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,180.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,293.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	571.30	894.30
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	351.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	719.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	84,290.08	4,321.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	84,290.08	4,321.30

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: 08/29/2018
Run Time: 00:48:36
Page: 15

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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF AUGUSTA, LLC
 3651 WHEELER RD
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	122,259,540.52	ADJUSTMENTS	6,639,711.71
COVERED CHARGES	117,824,978.27	CONTRACTUAL ALLOW	103,632,198.94
NON-COVERD CHARGES	4,434,562.25	TOTAL MEDICAID LIAB	14,192,779.33
		LESS: COB	68,925.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,123,853.65

TOTAL NUMBER OF ADMISSIONS 804

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,684		38	1,592,507.00		688,615.00
ROUTINE NURSERY	137		0	138,682.00		54,330.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,821		38	1,731,189.00		742,945.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,907		0	6,048,996.31		17,355.00
NICU	2		0	7,243.00		0.00
PED ICU	4		0	13,024.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	1		0	4,980.00		0.00
BURN UNIT	1,433		0	12,020,620.92		210,627.08
HOSPICE	0		0	0.00		0.00
REHAB	0		182	0.00		306,798.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,347		182	18,094,864.23		534,780.08
TOTAL ACCOMODATIONS	5,168		220	19,826,053.23		1,277,725.08

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,933,014.66	201,877.78	OTHER LAB	515,581.08	10,655.36
MED/SURG SUPPLY	13,888,803.50	300,114.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,909,748.03	189,753.70	EDUCATION & TRAINING	202.00	0.00
RADIOLOGY-DIAGNOSTIC	1,184,677.77	8,347.18	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,020,555.93	438,341.61	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	637,848.64	16,070.04	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	357,582.38	848.84	MRI SERVICES	447,173.32	0.00
IV THERAPY	41,458.76	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,217,904.36	224,250.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	273,787.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,473,460.21	1,123.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,000.00	400.00	AMBULANCE	0.00	0.00
GI SERVICES	247,527.90	5,115.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	998,760.37	1,586.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,867,383.49	36,788.79	DRUG-SPECIFIC/HOME IV	0.00	51,278.21
LABORATORY PATHOLOGIC	291,630.84	0.00	INJECTABLE DRUGS	25,330,250.60	608,514.04
RADIOLOGY THERAPEUTIC	237,135.05	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	970,484.46	21,287.35	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	119,237.58	1,257.88	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	353,625.31	36,162.50	PATIENT CONVENIENCE	0.00	5,049.32
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,552.34	38,364.73	TRAUMA RESPONSE	0.00	11,325.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	942,435.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	454,995.51	14,293.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	687,206.57	928,934.51			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	242,245.67	3,034.94			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,104,534.54	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	115,140.21	2,060.49			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	107,981.34	0.00			
			TOTAL ANCILLARY	97,998,925.04	3,156,837.17
			TOTAL ACCOMODATIONS	19,826,053.23	1,277,725.08
			TOTAL CHARGES	117,824,978.27	4,434,562.25

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: 08/29/2018
Run Time: 00:44:16
Page: 3

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	5917081002037	01/16/17 - 02/02/17	03/27/17	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	462,445.08	ADJUSTMENTS	0.00
COVERED CHARGES	449,440.08	CONTRACTUAL ALLOW	372,833.38
NON-COVERD CHARGES	13,005.00	TOTAL MEDICAID LIAB	76,606.70
		LESS: COB	76,606.70
		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	45		0	44,595.00		13,005.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	45		0	44,595.00		13,005.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	45		0	44,595.00		13,005.00

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,699.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65,132.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,654.33	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,862.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,003.95	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	21,399.02	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,943.85	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,263.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,115.00	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	2,659.14	0.00	INJECTABLE DRUGS	63,102.83	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,973.50	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	117.98	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,918.38	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	404,845.08	0.00
			TOTAL ACCOMODATIONS	44,595.00	13,005.00
			TOTAL CHARGES	449,440.08	13,005.00

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: 08/29/2018
Run Time: 00:44:23
Page: 6

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,431,169.07	ADJUSTMENTS	60,996.62
COVERED CHARGES	19,720,307.99	CONTRACTUAL ALLOW	18,105,977.95
NON-COVERD CHARGES	2,710,861.08	TOTAL MEDICAID LIAB	1,614,330.04
		LESS: COB	4,613.94
		LESS: COPAYMENT	4,939.12
		REIMBURSEMENT	1,604,776.98
		ALL OTHER	1,467,274.12
		FEE SCHEDULE-LAB	119,434.45
		INJECTABLE DRUGS	18,068.41
		TOTAL NUMBER OF CLAIMS	4,733

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	266,320.54	431.17	OTHER LAB	104,971.77	2,366.45
MED/SURG SUPPLY	1,186,612.77	7,167.69	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	792,536.28	14,023.01	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,933,394.52	335,494.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,103.17	54,433.08	FEE SCHEDULE LAB	1,575,482.29	75,317.92
EKG/ECG	425,385.76	1,571.92	MRI SERVICES	130,973.09	31,474.03
IV THERAPY	737,531.84	3,975.57	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,597,826.36	1,086,365.23	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	359,971.48	13,494.22	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	149,482.74	35,452.94	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,000.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	246,476.28	77,179.44	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,707,284.63	12,564.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,309,506.02	16,642.86	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	176,388.31	8,620.49
RADIOLOGY THERAPEUTIC	829,183.21	230,500.32	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,884.63	14,657.27	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	488.58	1,850.81	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,446.50	PATIENT CONVENIENCE	0.00	90.95
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	202,573.62	22,365.65	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	128,617.75	16,843.25
LITHOTRIPSY	82,284.44	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	470,840.23	113,681.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,047.25	3,490.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	331,006.13	351,586.19			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	311,859.64	129,455.33			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,857.46	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	543,417.20	48,317.77			
			TOTAL ANCILLARY	19,720,307.99	2,710,861.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,720,307.99	2,710,861.08

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

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

Run Date: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	598,123.06	ADJUSTMENTS	0.00
COVERED CHARGES	448,163.75	CONTRACTUAL ALLOW	334,804.58
NON-COVERD CHARGES	149,959.31	TOTAL MEDICAID LIAB	113,359.17
		LESS: COB	113,314.13
		LESS: COPAYMENT	45.04
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 87

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

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,780.94	0.00	OTHER LAB	768.33	0.00
MED/SURG SUPPLY	23,620.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,411.93	630.92	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,767.95	17,869.39	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,173.56	405.04
EKG/ECG	3,633.26	0.00	MRI SERVICES	0.00	2,398.51
IV THERAPY	3,624.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	177,046.77	93,613.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	4,629.24	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,071.90	3,941.16	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	10,639.20	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,657.82	928.91	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,876.37	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,871.34	728.84
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	54.57
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	708.23	129.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,452.17	2,363.66			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,001.92	2,215.07			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,696.27	9,411.16			
			TOTAL ANCILLARY	448,163.75	149,959.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	448,163.75	149,959.31

Report : CLM-0808-0
Process : CLMJ0800
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: 08/29/2018
Run Time: 00:44:45
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	916,035.81	ADJUSTMENTS	264.70
COVERED CHARGES	877,259.43	CONTRACTUAL ALLOW	851,750.79
NON-COVERD CHARGES	38,776.38	TOTAL MEDICAID LIAB	25,508.64
		LESS: COB	0.00
		LESS: COPAYMENT	753.00
		REIMBURSEMENT	24,755.64
		TOTAL NUMBER OF CLAIMS	456

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,716.91	0.00	OTHER LAB	1,600.05	0.00
MED/SURG SUPPLY	2,664.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,617.84	692.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	164,216.49	23,355.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,123.07	3,194.86
EKG/ECG	21,063.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	55,572.16	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,761.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,033.92	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	434,426.68	1,439.46	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,245.77	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,891.48	608.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	174.60	117.98	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,790.39	9,367.93			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,361.00	0.00			
			TOTAL ANCILLARY	877,259.43	38,776.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	877,259.43	38,776.38

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

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,428.86	ADJUSTMENTS	0.00
COVERED CHARGES	22,285.02	CONTRACTUAL ALLOW	13,555.20
NON-COVERD CHARGES	3,143.84	TOTAL MEDICAID LIAB	8,729.82
		LESS: COB	8,723.82
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	474.09	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,914.23	0.00
EKG/ECG	2,812.92	3,143.84	MRI SERVICES	0.00	0.00
IV THERAPY	1,080.70	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,666.76	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	25.96	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,285.02	3,143.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,285.02	3,143.84

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

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	857,903.82	ADJUSTMENTS	0.00
COVERED CHARGES	842,039.67	CONTRACTUAL ALLOW	792,197.74
NON-COVERD CHARGES	15,864.15	TOTAL MEDICAID LIAB	49,841.93
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	49,757.93

TOTAL NUMBER OF CLAIMS 9

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,016.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42,773.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,813.95	463.89	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	419.00	FEE SCHEDULE LAB	2,726.56	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	2,488.48
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	190,190.76	12,090.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	30,214.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	958.51	0.00
RADIOLOGY THERAPEUTIC	427,126.29	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	402.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	192.92	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	133,806.25	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	5,220.54	0.00			
			TOTAL ANCILLARY	842,039.67	15,864.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	842,039.67	15,864.15

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

Run Date: 08/29/2018
Run Time: 00:44:49
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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	04/01/16	THROUGH	03/31/17
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: 08/29/2018
 Run Time: 00:27:52
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
 901 GRIFFIN AVE
 EASTMAN,GA 31023-6720

PROVIDER NUMBER 000000591A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,458,694.40	ADJUSTMENTS	40,427.50
COVERED CHARGES	3,347,703.17	CONTRACTUAL ALLOW	1,915,583.05
NON-COVERD CHARGES	110,991.23	TOTAL MEDICAID LIAB	1,432,120.12
		LESS: COB	6,101.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,426,019.09

TOTAL NUMBER OF ADMISSIONS 194

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	862		0	646,500.00		96,425.00
ROUTINE NURSERY	8		0	3,480.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		950.00
TOTAL ROUTINE	870		0	649,980.00		97,375.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	121		0	176,660.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	121		0	176,660.00		0.00
TOTAL ACCOMODATIONS	991		0	826,640.00		97,375.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,339.77	0.00	OTHER LAB	7,628.23	0.00
MED/SURG SUPPLY	256,187.41	515.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	398,212.32	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,723.99	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	167,506.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,090.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	40,713.96	0.00	MRI SERVICES	4,516.79	0.00
IV THERAPY	56,654.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	180,358.58	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,006.31	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	354,216.05	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,068.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,654.47	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	155,134.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,531.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,451.53	0.00	INJECTABLE DRUGS	157,119.22	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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	608.58	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	192,601.74	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,616.23	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,609.02	12,899.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,384.22	201.89			
AUDIOLOGY	869.81	0.00			
CARDIOLOGY	12,876.90	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	484.55	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,896.84	0.00			
			TOTAL ANCILLARY	2,521,063.17	13,616.23
			TOTAL ACCOMODATIONS	826,640.00	97,375.00
			TOTAL CHARGES	3,347,703.17	110,991.23

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,164.62	ADJUSTMENTS	0.00
COVERED CHARGES	11,039.62	CONTRACTUAL ALLOW	4,393.17
NON-COVERD CHARGES	125.00	TOTAL MEDICAID LIAB	6,646.45
		LESS: COB	6,646.45
		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	5		0	3,750.00		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	5		0	3,750.00		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	5		0	3,750.00		125.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL
 901 GRIFFIN AVE
 EASTMAN,GA 31023-6720

PROVIDER NUMBER
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,110.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	295.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,183.71	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	626.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,536.13	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
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,537.16	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,289.62	0.00
			TOTAL ACCOMODATIONS	3,750.00	125.00
			TOTAL CHARGES	11,039.62	125.00

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: 08/29/2018
Run Time: 00:27:54
Page: 5

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,245,490.50	ADJUSTMENTS	82,513.29
COVERED CHARGES	3,146,004.45	CONTRACTUAL ALLOW	2,588,319.34
NON-COVERD CHARGES	99,486.05	TOTAL MEDICAID LIAB	557,685.11
		LESS: COB	3,060.21
		LESS: COPAYMENT	2,307.81
		REIMBURSEMENT	552,317.09
		ALL OTHER	490,785.99
		FEE SCHEDULE-LAB	58,466.66
		INJECTABLE DRUGS	3,064.44

TOTAL NUMBER OF CLAIMS 1,906

DODGE COUNTY HOSPITAL
 901 GRIFFIN AVE
 EASTMAN,GA 31023-6720

PROVIDER NUMBER
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,761.07	396.09	OTHER LAB	119,881.22	0.00
MED/SURG SUPPLY	209,321.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199,355.83	3,015.39	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	417,679.67	12,660.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,680.60	3,491.47	FEE SCHEDULE LAB	534,219.76	22,329.98
EKG/ECG	67,162.82	2,298.50	MRI SERVICES	150,996.12	0.00
IV THERAPY	146,498.21	4,329.84	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	178,285.16	14,455.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	46,057.23	4,349.91	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,492.15	1,167.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	132,136.06	0.00	AMBULANCE	0.00	0.00
GI SERVICES	28,468.15	2,802.76	CAST ROOM	0.00	0.00
EMERGENCY ROOM	550,317.36	61.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,816.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,789.08	11,643.46
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	139.42	1,542.39	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,689.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,754.69	4,623.11			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,873.28	1,547.94			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,460.35	4,725.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,925.56	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	484.55	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,759.67	4,045.01			
			TOTAL ANCILLARY	3,146,004.45	99,486.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,146,004.45	99,486.05

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,752.25	ADJUSTMENTS	0.00
COVERED CHARGES	40,625.33	CONTRACTUAL ALLOW	14,787.99
NON-COVERD CHARGES	7,126.92	TOTAL MEDICAID LIAB	25,837.34
		LESS: COB	25,783.34
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 28

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

DODGE COUNTY HOSPITAL
 901 GRIFFIN AVE
 EASTMAN,GA 31023-6720

PROVIDER NUMBER
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	575.80	0.00	OTHER LAB	5,397.85	0.00
MED/SURG SUPPLY	4,340.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	414.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,846.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,391.18	0.00	FEE SCHEDULE LAB	5,247.79	188.51
EKG/ECG	261.30	0.00	MRI SERVICES	6,120.00	0.00
IV THERAPY	380.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,666.36	1,666.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,335.94	626.88	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,025.93	225.11	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,423.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	502.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	219.02	573.72
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	2,129.73	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	794.73	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,287.69	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112.00	0.00			
			TOTAL ANCILLARY	40,625.33	7,126.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,625.33	7,126.92

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: 08/29/2018
Run Time: 00:27:59
Page: 9

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,907.04	ADJUSTMENTS	55.94
COVERED CHARGES	166,560.64	CONTRACTUAL ALLOW	153,862.26
NON-COVERD CHARGES	1,346.40	TOTAL MEDICAID LIAB	12,698.38
		LESS: COB	0.00
		LESS: COPAYMENT	504.00
		REIMBURSEMENT	12,194.38
		TOTAL NUMBER OF CLAIMS	227

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,491.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,381.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,264.61	201.94	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,422.11	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,057.79	1,099.22
EKG/ECG	2,120.44	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,355.89	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	793.27	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	116,300.55	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	2,234.10	45.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139.42	0.00			
			TOTAL ANCILLARY	166,560.64	1,346.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	166,560.64	1,346.40

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: 08/29/2018
Run Time: 00:28:00
Page: 11

DODGE COUNTY HOSPITAL
901 GRIFFIN AVE
EASTMAN,GA 31023-6720

PROVIDER NUMBER
000000591A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,825.17	ADJUSTMENTS	0.00
COVERED CHARGES	15,641.71	CONTRACTUAL ALLOW	11,501.91
NON-COVERD CHARGES	7,183.46	TOTAL MEDICAID LIAB	4,139.80
		LESS: COB	4,112.67
		LESS: COPAYMENT	27.13
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	244.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	843.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	336.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,039.02	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,961.77	144.44
EKG/ECG	908.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,737.44	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,385.20	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	223.43	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	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,641.71	7,183.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,641.71	7,183.46

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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
Run Time: 00:28:01
Page: 14

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	10/01/16	THROUGH	09/30/17
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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,055,069.93	ADJUSTMENTS	52,180.81
COVERED CHARGES	1,997,695.18	CONTRACTUAL ALLOW	1,211,249.63
NON-COVERD CHARGES	57,374.75	TOTAL MEDICAID LIAB	786,445.55
		LESS: COB	23,360.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	763,085.42

TOTAL NUMBER OF ADMISSIONS 151

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	261		0	130,984.50		8,418.75
ROUTINE NURSERY	66		0	17,836.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	327		0	148,820.50		8,418.75
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	120		0	150,480.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	120		0	150,480.00		0.00
TOTAL ACCOMODATIONS	447		0	299,300.50		8,418.75

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

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

Run Date: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	243,630.02	21,777.50	OTHER LAB	12,722.75	0.00
MED/SURG SUPPLY	168,261.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	352,390.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,433.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	190,048.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,840.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	35,459.00	0.00	MRI SERVICES	27,592.75	0.00
IV THERAPY	2,411.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	106,720.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,791.75	13,124.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150,144.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,381.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	119,853.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,116.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,553.00	0.00	INJECTABLE DRUGS	79,507.50	0.00
RADIOLOGY THERAPEUTIC	0.00	220.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,153.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,721.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,962.00	10,934.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,256.25	160.00			
AUDIOLOGY	2,056.50	0.00			
CARDIOLOGY	35,245.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142.00	2,738.75			
			TOTAL ANCILLARY	1,698,394.68	48,956.00
			TOTAL ACCOMODATIONS	299,300.50	8,418.75
			TOTAL CHARGES	1,997,695.18	57,374.75

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

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	08/01/16	THROUGH	07/31/17
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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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,903,050.10	ADJUSTMENTS	15,688.89
COVERED CHARGES	3,481,357.46	CONTRACTUAL ALLOW	2,765,371.42
NON-COVERD CHARGES	421,692.64	TOTAL MEDICAID LIAB	715,986.04
		LESS: COB	1,221.02
		LESS: COPAYMENT	1,653.00
		REIMBURSEMENT	713,112.02
		ALL OTHER	620,584.26
		FEE SCHEDULE-LAB	75,366.88
		INJECTABLE DRUGS	17,160.88

TOTAL NUMBER OF CLAIMS 1,988

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,456.22	82,141.50	OTHER LAB	26,733.75	0.00
MED/SURG SUPPLY	106,698.12	271.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203,557.50	14,859.75	OTHER THERAPEUTIC SVC	0.00	3,034.25
CT SCAN	609,893.75	54,922.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,236.25	2,957.25	FEE SCHEDULE LAB	826,272.50	61,610.50
EKG/ECG	76,317.50	11,894.00	MRI SERVICES	111,409.50	0.00
IV THERAPY	108,517.75	8,330.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	160,785.12	27,368.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,662.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,919.00	9,587.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,025.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	619,276.50	4,301.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,224.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105,694.25	20,739.00
RADIOLOGY THERAPEUTIC	14,760.50	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	773.50	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	4,688.00	974.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	754.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	167.00
OTHER IMAGING SERVICE	66,036.00	13,638.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,709.00	2,750.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,810.25	39,790.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,402.00	42,817.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	83,629.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	69,642.25	18,009.00			
			TOTAL ANCILLARY	3,481,357.46	421,692.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,481,357.46	421,692.64

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

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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8006	2217270000673	03/22/17 - 03/22/17	10/02/17	0.00	167.00	0.00	0.00	0.00
TOTAL				0.00	167.00	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

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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,622.45	ADJUSTMENTS	0.00
COVERED CHARGES	16,768.70	CONTRACTUAL ALLOW	6,389.42
NON-COVERD CHARGES	12,853.75	TOTAL MEDICAID LIAB	10,379.28
		LESS: COB	10,358.10
		LESS: COPAYMENT	21.18
		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

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	577.25	290.50	OTHER LAB	741.50	0.00
MED/SURG SUPPLY	542.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,191.25	808.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,467.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,260.50	749.25
EKG/ECG	325.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	105.50	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	3,403.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	223.50	0.00
RADIOLOGY THERAPEUTIC	2,665.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	134.75	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	704.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,433.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,768.70	12,853.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,768.70	12,853.75

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

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

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DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	595,887.34	ADJUSTMENTS	105.88
COVERED CHARGES	554,297.34	CONTRACTUAL ALLOW	527,054.56
NON-COVERD CHARGES	41,590.00	TOTAL MEDICAID LIAB	27,242.78
		LESS: COB	93.75
		LESS: COPAYMENT	1,074.09
		REIMBURSEMENT	26,074.94
		TOTAL NUMBER OF CLAIMS	487

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	887.25	10,090.50	OTHER LAB	2,224.50	0.00
MED/SURG SUPPLY	3,910.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,720.00	2,106.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	122,064.50	13,522.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	120,180.25	8,412.75
EKG/ECG	14,485.50	634.50	MRI SERVICES	2,896.75	0.00
IV THERAPY	3,894.75	287.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	1,221.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	227,862.75	171.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,746.50	1,162.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,890.50	3,981.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	199.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,117.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,052.25	0.00			
			TOTAL ANCILLARY	554,297.34	41,590.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	554,297.34	41,590.00

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
200 PERRY HOUSE RD
FITZGERALD,GA 31750-8857

PROVIDER NUMBER
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,753.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,966.00	CONTRACTUAL ALLOW	1,081.88
NON-COVERD CHARGES	787.00	TOTAL MEDICAID LIAB	1,884.12
		LESS: COB	1,884.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	166.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	673.50	27.75
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	1,669.50	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	623.00	593.25			
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	2,966.00	787.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,966.00	787.00

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

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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	103,304.73	ADJUSTMENTS	0.00
COVERED CHARGES	99,949.25	CONTRACTUAL ALLOW	88,858.79
NON-COVERD CHARGES	3,355.48	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	10,952.46

TOTAL NUMBER OF CLAIMS 2

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,086.00	133.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,549.25	37.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	302.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	505.75	58.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,192.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	724.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	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	2,020.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,872.00	2,824.00			
			TOTAL ANCILLARY	99,949.25	3,355.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	99,949.25	3,355.48

Report : 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: 08/29/2018
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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	08/01/16	THROUGH	07/31/17
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: 08/29/2018
 Run Time: 00:44:57
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,533,576.50	ADJUSTMENTS	217,431.19
COVERED CHARGES	25,400,568.21	CONTRACTUAL ALLOW	19,895,112.93
NON-COVERD CHARGES	133,008.29	TOTAL MEDICAID LIAB	5,505,455.28
		LESS: COB	117,536.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,387,918.35

TOTAL NUMBER OF ADMISSIONS 619

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,579		0	1,942,170.00		98,290.00
ROUTINE NURSERY	135		0	58,046.00		62.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,714		0	2,000,216.00		98,352.00
SPECIAL CARE SERVICES						
CCU	655		0	1,595,182.00		0.00
ICU	390		0	1,342,770.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,045		0	2,937,952.00		0.00
TOTAL ACCOMODATIONS	2,759		0	4,938,168.00		98,352.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,983,706.25	0.00	OTHER LAB	133,638.00	0.00
MED/SURG SUPPLY	799,212.80	46.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,045,142.00	0.00	EDUCATION & TRAINING	1,560.00	0.00
RADIOLOGY-DIAGNOSTIC	578,776.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,315.00
CT SCAN	1,671,460.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,394.34	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	211,878.00	0.00	MRI SERVICES	228,328.00	0.00
IV THERAPY	509,217.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	971,376.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	380,505.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,868,170.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	502,731.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,402,773.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	155,858.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,643.25
LABORATORY PATHOLOGIC	149,781.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	33,694.15	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,408,781.00	25,007.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,868.00	691.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	15,749.00	0.00	IMPL DEV CHARGE PATIENTS	295,612.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	612.00
OTHER IMAGING SERVICE	154,349.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	456,414.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	169,740.00	342.00			
AUDIOLOGY	25,020.00	0.00			
CARDIOLOGY	934,438.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,314.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	249,914.15	0.00			
			TOTAL ANCILLARY	20,462,400.21	34,656.29
			TOTAL ACCOMODATIONS	4,938,168.00	98,352.00
			TOTAL CHARGES	25,400,568.21	133,008.29

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2317080000140	12/29/16 - 12/31/16	04/24/17	0.00	153.00	0.00	1,399.81	0.00
780	2317125000193	12/13/16 - 12/19/16	05/29/17	0.00	153.00	0.00	0.00	0.00
780	2017243052207	02/28/17 - 03/02/17	09/04/17	0.00	153.00	0.00	0.00	0.00
780	2018211010527	04/23/17 - 04/26/17	08/06/18	0.00	153.00	0.00	0.00	0.00
TOTAL				0.00	612.00	0.00	1,399.81	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: 08/29/2018
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000624A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	279,061.60	ADJUSTMENTS	0.00
COVERED CHARGES	277,759.60	CONTRACTUAL ALLOW	150,750.89
NON-COVERD CHARGES	1,302.00	TOTAL MEDICAID LIAB	127,008.71
		LESS: COB	127,008.71
		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	21		0	25,830.00		1,302.00
ROUTINE NURSERY	0		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	25,830.00		1,302.00
SPECIAL CARE SERVICES						
CCU	8		0	19,488.00		0.00
ICU	6		0	20,658.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	40,146.00		0.00
TOTAL ACCOMODATIONS	35		0	65,976.00		1,302.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,804.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,885.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	54,478.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,017.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,388.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,764.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,979.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,992.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,025.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,698.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,151.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	464.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	222.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,545.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,942.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	534.13	0.00			
			TOTAL ANCILLARY	211,783.60	0.00
			TOTAL ACCOMODATIONS	65,976.00	1,302.00
			TOTAL CHARGES	277,759.60	1,302.00

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: 08/29/2018
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Page: 6

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,250,174.66	ADJUSTMENTS	218,269.10
COVERED CHARGES	16,993,767.52	CONTRACTUAL ALLOW	14,628,141.10
NON-COVERD CHARGES	1,256,407.14	TOTAL MEDICAID LIAB	2,365,626.42
		LESS: COB	19,227.53
		LESS: COPAYMENT	3,354.72
		REIMBURSEMENT	2,343,044.17
		ALL OTHER	2,060,296.60
		FEE SCHEDULE-LAB	186,425.95
		INJECTABLE DRUGS	96,321.62

TOTAL NUMBER OF CLAIMS 5,086

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

PROVIDER NUMBER
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	448,176.22	8,704.75	OTHER LAB	276,420.00	0.00
MED/SURG SUPPLY	212,142.44	8,550.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	984,109.00	17,250.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,783,920.00	192,429.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,565.00	12,429.02	FEE SCHEDULE LAB	2,501,876.70	99,133.63
EKG/ECG	252,804.00	4,917.00	MRI SERVICES	597,621.00	59,902.00
IV THERAPY	903,098.00	6,910.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	800,939.00	59,391.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	40,396.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	160,069.00	117,037.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	393,524.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,561.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,137,463.00	2,101.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,416.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	414,147.00	340,951.75
RADIOLOGY THERAPEUTIC	1,179.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,852.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	29,940.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	115,420.00	22,401.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	32,274.00	70,212.00	IMPL DEV CHARGE PATIENTS	24,770.56	30,708.01
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	918.00
OTHER IMAGING SERVICE	570,333.00	51,082.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,473.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	332,035.00	51,732.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	279,046.00	61,996.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	321,670.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	193,319.60	4,859.83			
			TOTAL ANCILLARY	16,993,767.52	1,256,407.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,993,767.52	1,256,407.14

Report : CLM-0804-0
Process : CLMJ0800
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 DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016305012911	09/30/16 - 09/30/16	11/07/16	0.00	75.00	0.00	0.00	0.00
780	2016305012911	09/30/16 - 09/30/16	11/07/16	0.00	78.00	0.00	0.00	0.00
780	2016316058255	10/15/16 - 10/15/16	11/14/16	0.00	75.00	0.00	0.00	0.00
780	2016316058255	10/15/16 - 10/15/16	11/14/16	0.00	78.00	0.00	0.00	0.00
780	5917045001062	12/12/16 - 12/12/16	02/20/17	0.00	75.00	0.00	0.00	0.00
780	5917045001062	12/12/16 - 12/12/16	02/20/17	0.00	78.00	0.00	0.00	0.00
780	2017100015536	03/23/17 - 03/23/17	04/17/17	0.00	75.00	0.00	0.00	0.00
780	2017100015536	03/23/17 - 03/23/17	04/17/17	0.00	78.00	0.00	0.00	0.00
780	2318004000029	11/11/16 - 11/11/16	01/22/18	0.00	75.00	0.00	0.00	0.00
780	2318004000029	11/11/16 - 11/11/16	01/22/18	0.00	78.00	0.00	0.00	0.00
780	5918213001807	11/09/16 - 11/09/16	08/06/18	0.00	75.00	0.00	0.00	0.00
780	5918213001807	11/09/16 - 11/09/16	08/06/18	0.00	78.00	0.00	0.00	0.00
TOTAL				0.00	918.00	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 DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	241,233.62	ADJUSTMENTS	0.00
COVERED CHARGES	216,871.26	CONTRACTUAL ALLOW	107,636.05
NON-COVERD CHARGES	24,362.36	TOTAL MEDICAID LIAB	109,235.21
		LESS: COB	109,213.02
		LESS: COPAYMENT	22.19
		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

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

PROVIDER NUMBER
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,781.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,702.36	579.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,540.00	1,408.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,751.00	8,481.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,184.60	1,892.86
EKG/ECG	3,589.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,378.00	185.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,963.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	814.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	320.00	1,527.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,912.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,471.00	1,944.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,062.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	1,219.50
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	2,250.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,659.00	4,372.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	504.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,318.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	426.30	0.00			
			TOTAL ANCILLARY	216,871.26	24,362.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	216,871.26	24,362.36

Report : CLM-0808-0
Process : CLMJ0800
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 DOUGLAS HOSPITAL
8954 HOSPITAL DR
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	884,139.13	ADJUSTMENTS	220.76
COVERED CHARGES	859,584.63	CONTRACTUAL ALLOW	836,128.77
NON-COVERD CHARGES	24,554.50	TOTAL MEDICAID LIAB	23,455.86
		LESS: COB	1,532.79
		LESS: COPAYMENT	648.00
		REIMBURSEMENT	21,275.07
		TOTAL NUMBER OF CLAIMS	393

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,276.00	600.00	OTHER LAB	14,917.00	0.00
MED/SURG SUPPLY	4,412.08	190.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,452.00	1,126.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	117,195.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	157,143.00	6,284.00
EKG/ECG	11,175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	41,226.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,171.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,465.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,096.00	1,081.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,688.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	398,575.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,355.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	174.50
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	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,276.00	9,078.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,401.00	5,910.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,406.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,355.55	0.00			
			TOTAL ANCILLARY	859,584.63	24,554.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	859,584.63	24,554.50

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,333.75	ADJUSTMENTS	0.00
COVERED CHARGES	17,085.75	CONTRACTUAL ALLOW	9,855.80
NON-COVERD CHARGES	248.00	TOTAL MEDICAID LIAB	7,229.95
		LESS: COB	7,223.95
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	684.75	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	665.00	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	2,410.00	248.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	637.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,535.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,085.75	248.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,085.75	248.00

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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,042,258.35	ADJUSTMENTS	49,278.12
COVERED CHARGES	1,034,154.35	CONTRACTUAL ALLOW	886,067.99
NON-COVERD CHARGES	8,104.00	TOTAL MEDICAID LIAB	148,086.36
		LESS: COB	0.00
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	147,819.36

TOTAL NUMBER OF CLAIMS 27

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,311.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,109.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,938.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,090.00	392.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	33,716.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,461.00	3,250.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,520.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,376.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,595.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,700.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	722,861.75	1,209.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,347.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,617.20	0.00
LITHOTRIPSY	69,368.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,353.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	29,723.00	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	3,620.05	0.00			
			TOTAL ANCILLARY	1,034,154.35	8,104.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,034,154.35	8,104.00

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

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

PROVIDER NUMBER
000000624A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER 000000635A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 10/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	418,737.00	ADJUSTMENTS	14,351.22
COVERED CHARGES	412,872.00	CONTRACTUAL ALLOW	205,482.68
NON-COVERD CHARGES	5,865.00	TOTAL MEDICAID LIAB	207,389.32
		LESS: COB	5,030.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	202,358.80

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	150		0	81,000.00		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	150		0	81,000.00		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	150		0	81,000.00		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: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
 11740 COLUMBIA ST
 BLAKELY,GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 10/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,658.00	0.00	OTHER LAB	2,584.00	0.00
MED/SURG SUPPLY	41,416.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	85,327.00	0.00	EDUCATION & TRAINING	252.00	0.00
RADIOLOGY-DIAGNOSTIC	5,728.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,368.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,407.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	880.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	580.00	580.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,069.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,573.00	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	20,612.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	465.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,405.00
OTHER IMAGING SERVICE	1,320.00	0.00			
BLOOD	2,373.00	0.00			
BLOOD STORAGE & PRO.	2,373.00	2,880.00			
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	2,185.00	0.00			
			TOTAL ANCILLARY	331,872.00	5,865.00
			TOTAL ACCOMODATIONS	81,000.00	0.00
			TOTAL CHARGES	412,872.00	5,865.00

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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LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 10/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017063000970	02/18/17 - 02/24/17	03/13/17	0.00	2,405.00	0.00	0.00	0.00
TOTAL				0.00	2,405.00	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

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	10/31/17
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: 08/29/2018
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LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 10/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	850,212.51	ADJUSTMENTS	35,507.63
COVERED CHARGES	772,211.48	CONTRACTUAL ALLOW	521,129.60
NON-COVERD CHARGES	78,001.03	TOTAL MEDICAID LIAB	251,081.88
		LESS: COB	0.00
		LESS: COPAYMENT	966.00
		REIMBURSEMENT	250,115.88
		ALL OTHER	206,914.89
		FEE SCHEDULE-LAB	24,071.02
		INJECTABLE DRUGS	19,129.97

TOTAL NUMBER OF CLAIMS 800

Report : CLM-0804-0
 Process : CLMJ0800
 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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LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 10/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,920.84	0.00	OTHER LAB	1,320.00	0.00
MED/SURG SUPPLY	10,499.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,447.00	3,055.00	OTHER THERAPEUTIC SVC	0.00	840.00
CT SCAN	99,669.00	39,268.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	198.00	198.03	FEE SCHEDULE LAB	250,259.00	18,732.00
EKG/ECG	3,876.00	80.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,256.00	444.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,871.00	1,775.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,791.00	2,487.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	874.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	224,458.00	238.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	180.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,907.64	5,810.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,640.00	880.00			
BLOOD	1,017.00	1,017.00			
BLOOD STORAGE & PRO.	1,017.00	3,177.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,316.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,695.00	0.00			
			TOTAL ANCILLARY	772,211.48	78,001.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	772,211.48	78,001.03

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

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 10/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,142.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,731.00	CONTRACTUAL ALLOW	460.75
NON-COVERD CHARGES	1,411.00	TOTAL MEDICAID LIAB	5,270.25
		LESS: COB	5,270.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
 11740 COLUMBIA ST
 BLAKELY, GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 10/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,424.00	38.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	10.00	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
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	5,731.00	1,411.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,731.00	1,411.00

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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LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 10/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,102.00	ADJUSTMENTS	141.00
COVERED CHARGES	105,017.00	CONTRACTUAL ALLOW	100,317.00
NON-COVERD CHARGES	5,085.00	TOTAL MEDICAID LIAB	4,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	159.00
		REIMBURSEMENT	4,541.00
		TOTAL NUMBER OF CLAIMS	94

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
 11740 COLUMBIA ST
 BLAKELY,GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 10/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	657.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	406.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,148.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,033.00	1,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,576.00	1,892.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	105.00	0.00	PROFESSIONAL FEES	0.00	122.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,625.00	105.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,327.00	1,605.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	440.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,280.00	0.00			
			TOTAL ANCILLARY	105,017.00	5,085.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	105,017.00	5,085.00

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

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 10/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	615.00	ADJUSTMENTS	0.00
COVERED CHARGES	596.00	CONTRACTUAL ALLOW	120.25
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	475.75
		LESS: COB	472.75
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
 11740 COLUMBIA ST
 BLAKELY,GA 39823-2574

PROVIDER NUMBER
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 10/31/17
 ADMISSION DATES 00/00/00 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	187.00	19.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	409.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	596.00	19.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	596.00	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

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	10/31/17
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

LIFEBRITE HOSPITAL GROUP OF EARLY, LLC
11740 COLUMBIA ST
BLAKELY,GA 39823-2574

PROVIDER NUMBER
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	10/31/17
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

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 07/01/16 THROUGH 10/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	154,212.12	ADJUSTMENTS	9,845.87
COVERED CHARGES	113,937.32	CONTRACTUAL ALLOW	81,086.28
NON-COVERD CHARGES	40,274.80	TOTAL MEDICAID LIAB	32,851.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,851.04

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	24		0	24,192.00		36,387.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	24		0	24,192.00		36,387.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	24,192.00		36,387.00

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 07/01/16 THROUGH 10/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,994.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,496.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,049.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,863.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	452.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	541.42	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,232.18	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,463.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,526.89	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,147.13	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,270.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,728.56	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	255.54	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	514.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,748.83	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,887.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,310.00	0.00			
			TOTAL ANCILLARY	89,745.32	3,887.80
			TOTAL ACCOMODATIONS	24,192.00	36,387.00
			TOTAL CHARGES	113,937.32	40,274.80

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

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 07/01/16 THROUGH 10/31/16
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: 08/29/2018
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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 07/01/16 THROUGH 10/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,040,656.72	ADJUSTMENTS	10,910.70
COVERED CHARGES	950,194.06	CONTRACTUAL ALLOW	665,928.14
NON-COVERD CHARGES	90,462.66	TOTAL MEDICAID LIAB	284,265.92
		LESS: COB	1,967.40
		LESS: COPAYMENT	321.00
		REIMBURSEMENT	281,977.52
		ALL OTHER	263,842.51
		FEE SCHEDULE-LAB	15,569.65
		INJECTABLE DRUGS	2,565.36

TOTAL NUMBER OF CLAIMS 530

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 07/01/16 THROUGH 10/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,921.17	289.00	OTHER LAB	16,084.39	0.00
MED/SURG SUPPLY	28,373.62	90.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97,467.05	905.13	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	119,483.16	48,925.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,165.09	0.00	FEE SCHEDULE LAB	163,139.51	7,059.26
EKG/ECG	14,618.34	0.00	MRI SERVICES	31,635.62	3,403.67
IV THERAPY	37,101.13	142.58	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,106.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,222.19	881.92	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,175.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,063.42	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	234,593.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,434.58	1,296.56	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,777.64	11,203.30
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	1,852.48	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,216.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,257.07	4,442.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,979.23	300.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,595.00	7,455.00			
			TOTAL ANCILLARY	950,194.06	90,462.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	950,194.06	90,462.66

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

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 07/01/16 THROUGH 10/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,536.62	ADJUSTMENTS	0.00
COVERED CHARGES	18,711.92	CONTRACTUAL ALLOW	7,231.49
NON-COVERD CHARGES	824.70	TOTAL MEDICAID LIAB	11,480.43
		LESS: COB	11,474.63
		LESS: COPAYMENT	5.80
		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

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 07/01/16 THROUGH 10/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	413.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	387.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	437.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,669.03	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,254.27	224.70
EKG/ECG	270.71	0.00	MRI SERVICES	4,738.71	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,153.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45.00	126.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	342.70	474.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,711.92	824.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,711.92	824.70

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

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

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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 07/01/16 THROUGH 10/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,350.26	ADJUSTMENTS	0.00
COVERED CHARGES	73,362.81	CONTRACTUAL ALLOW	70,012.81
NON-COVERD CHARGES	987.45	TOTAL MEDICAID LIAB	3,350.00
		LESS: COB	0.00
		LESS: COPAYMENT	126.89
		REIMBURSEMENT	3,223.11
		TOTAL NUMBER OF CLAIMS	67

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 07/01/16 THROUGH 10/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	520.70	0.00	OTHER LAB	777.31	0.00
MED/SURG SUPPLY	234.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,730.36	438.71	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,007.26	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,457.04	64.20
EKG/ECG	1,624.26	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,573.38	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,350.24	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	370.00	321.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	163.54	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	718.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	73,362.81	987.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,362.81	987.45

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: 08/29/2018
Run Time: 00:50:13
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 07/01/16 THROUGH 10/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,177.06	ADJUSTMENTS	0.00
COVERED CHARGES	3,144.96	CONTRACTUAL ALLOW	1,456.69
NON-COVERD CHARGES	32.10	TOTAL MEDICAID LIAB	1,688.27
		LESS: COB	1,685.27
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/16 THROUGH 10/31/16
 ADMISSION DATES 00/00/00 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	32.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	437.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	886.80	32.10
EKG/ECG	270.71	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,517.32	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,144.96	32.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,144.96	32.10

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

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 07/01/16 THROUGH 10/31/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,954.40	ADJUSTMENTS	0.00
COVERED CHARGES	26,673.70	CONTRACTUAL ALLOW	19,824.40
NON-COVERD CHARGES	280.70	TOTAL MEDICAID LIAB	6,849.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,849.30

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 07/01/16 THROUGH 10/31/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,429.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,700.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,503.63	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,037.50	64.20
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,728.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,818.21	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	1,105.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,912.54	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,297.91	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	774.14	216.50
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	1,365.00	0.00			
			TOTAL ANCILLARY	26,673.70	280.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,673.70	280.70

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: 08/29/2018
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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	07/01/16	THROUGH	10/31/16
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

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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	390,647.16	ADJUSTMENTS	60,801.31
COVERED CHARGES	307,420.82	CONTRACTUAL ALLOW	206,636.37
NON-COVERD CHARGES	83,226.34	TOTAL MEDICAID LIAB	100,784.45
		LESS: COB	4,291.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	96,493.07

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	55		0	55,440.00		83,160.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	55		0	55,440.00		83,160.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	55		0	55,440.00		83,160.00

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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,605.13	0.00	OTHER LAB	2,510.24	0.00
MED/SURG SUPPLY	11,184.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,100.11	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,371.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,174.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,904.22	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,165.68	0.00	MRI SERVICES	14,341.96	0.00
IV THERAPY	2,975.52	0.00	PROFESSIONAL FEES	0.00	66.34
OPERATING ROOM	3,658.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58,787.80	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	8,108.82	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	447.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,019.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	514.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	896.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,961.14	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,255.00	0.00			
			TOTAL ANCILLARY	251,980.82	66.34
			TOTAL ACCOMODATIONS	55,440.00	83,160.00
			TOTAL CHARGES	307,420.82	83,226.34

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

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

Run Date: 08/29/2018
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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 11/01/16 THROUGH 06/30/17
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: 08/29/2018
Run Time: 00:50:22
Page: 4

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 11/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,996,437.28	ADJUSTMENTS	89,885.50
COVERED CHARGES	1,838,487.38	CONTRACTUAL ALLOW	1,316,875.04
NON-COVERD CHARGES	157,949.90	TOTAL MEDICAID LIAB	521,612.34
		LESS: COB	1,580.99
		LESS: COPAYMENT	804.00
		REIMBURSEMENT	519,227.35
		ALL OTHER	490,813.92
		FEE SCHEDULE-LAB	25,678.44
		INJECTABLE DRUGS	2,734.99

TOTAL NUMBER OF CLAIMS 940

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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,377.92	1,827.46	OTHER LAB	15,041.90	0.00
MED/SURG SUPPLY	30,809.49	397.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199,814.63	10,993.97	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	321,106.33	25,041.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,349.41	1,110.55	FEE SCHEDULE LAB	273,134.21	6,244.81
EKG/ECG	22,673.30	0.00	MRI SERVICES	79,385.14	9,603.25
IV THERAPY	80,647.31	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,316.78	3,274.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,472.43	2,754.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,173.39	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,877.68	9,336.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	428,573.11	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,729.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	97,816.35	62,987.89
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	981.24	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	800.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54,345.58	11,359.87			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,241.20			
ONCOLOGY	9,292.50	0.00			
NUCLEAR MEDICINE	3,690.23	835.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,737.28	3,961.14			
AMBULATORY SURGERY	4,241.95	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,881.00	4,200.00			
			TOTAL ANCILLARY	1,838,487.38	157,949.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,838,487.38	157,949.90

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

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

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 11/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,755.41	ADJUSTMENTS	0.00
COVERED CHARGES	14,144.81	CONTRACTUAL ALLOW	1,542.95
NON-COVERD CHARGES	13,610.60	TOTAL MEDICAID LIAB	12,601.86
		LESS: COB	12,598.86
		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

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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	547.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	520.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	457.39	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,858.70	192.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	403.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,274.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,676.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,296.56	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	641.88	12,870.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,468.07	548.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,144.81	13,610.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,144.81	13,610.60

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: 08/29/2018
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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 11/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	158,361.88	ADJUSTMENTS	91.00
COVERED CHARGES	155,995.14	CONTRACTUAL ALLOW	150,795.14
NON-COVERD CHARGES	2,366.74	TOTAL MEDICAID LIAB	5,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	4,975.00
		TOTAL NUMBER OF CLAIMS	104

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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,955.63	425.46	OTHER LAB	1,608.70	0.00
MED/SURG SUPPLY	701.67	76.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,688.64	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,938.83	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,898.81	544.60
EKG/ECG	1,353.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,016.23	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	250.38	500.76	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	85,026.30	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	2,402.40	819.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,154.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	155,995.14	2,366.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	155,995.14	2,366.74

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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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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,176.98	ADJUSTMENTS	0.00
COVERED CHARGES	4,176.98	CONTRACTUAL ALLOW	3,053.35
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,123.63
		LESS: COB	1,120.63
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	320.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	624.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	397.84	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	831.24	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,852.29	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	119.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,176.98	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,176.98	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

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 11/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,016.70	ADJUSTMENTS	6,846.30
COVERED CHARGES	23,612.70	CONTRACTUAL ALLOW	16,763.40
NON-COVERD CHARGES	1,404.00	TOTAL MEDICAID LIAB	6,849.30
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	6,846.30

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 11/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	640.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,600.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	1,268.00	OTHER THERAPEUTIC SVC	0.00	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	4,041.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,814.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	432.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	970.00	136.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	115.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,612.70	1,404.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,612.70	1,404.00

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: 08/29/2018
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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	11/01/16	THROUGH	06/30/17
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: 08/29/2018
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 Page: 1

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,069,722.74	ADJUSTMENTS	0.00
COVERED CHARGES	3,458,016.74	CONTRACTUAL ALLOW	2,525,133.61
NON-COVERD CHARGES	611,706.00	TOTAL MEDICAID LIAB	932,883.13
		LESS: COB	14,192.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	918,691.01

TOTAL NUMBER OF ADMISSIONS 154

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	893		0	442,827.00		598,576.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	893		0	442,827.00		598,576.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	113		0	124,526.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	113		0	124,526.00		0.00
TOTAL ACCOMODATIONS	1,006		0	567,353.00		598,576.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,165,227.30	0.00	OTHER LAB	10,646.00	0.00
MED/SURG SUPPLY	79,232.00	52.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	567,359.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,599.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	200,121.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,366.44	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	38,015.00	0.00	MRI SERVICES	9,736.00	0.00
IV THERAPY	88,056.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,862.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	190,723.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,467.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	235,570.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,030.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,257.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,728.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,061.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,889.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,564.00	12,779.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,652.00	299.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,447.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	42,056.00	0.00			
			TOTAL ANCILLARY	2,890,663.74	13,130.00
			TOTAL ACCOMODATIONS	567,353.00	598,576.00
			TOTAL CHARGES	3,458,016.74	611,706.00

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

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

Run Date: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
Run Time: 00:32:40
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,186,546.10	ADJUSTMENTS	9,294.65
COVERED CHARGES	4,969,734.20	CONTRACTUAL ALLOW	4,324,091.59
NON-COVERD CHARGES	216,811.90	TOTAL MEDICAID LIAB	645,642.61
		LESS: COB	2,276.94
		LESS: COPAYMENT	1,128.00
		REIMBURSEMENT	642,237.67
		ALL OTHER	560,218.87
		FEE SCHEDULE-LAB	82,013.68
		INJECTABLE DRUGS	5.12
		TOTAL NUMBER OF CLAIMS	1,998

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	420,392.20	23,492.00	OTHER LAB	22,979.00	0.00
MED/SURG SUPPLY	179,026.00	2,212.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	27.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	246,085.00	15,223.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	745,827.00	25,067.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	280.90	FEE SCHEDULE LAB	1,139,182.00	50,832.00
EKG/ECG	67,690.00	0.00	MRI SERVICES	86,651.00	5,212.00
IV THERAPY	316,354.00	2,806.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	135,947.00	9,259.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,054.00	151.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,813.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,147,782.00	21,084.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	665.00	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	688.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	11,919.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	122,297.00	10,713.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,754.00	4,118.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,520.00	14,344.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,904.00	10,746.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,124.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	163,888.00	8,343.00			
			TOTAL ANCILLARY	4,969,734.20	216,811.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,969,734.20	216,811.90

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,845.00	ADJUSTMENTS	0.00
COVERED CHARGES	36,279.00	CONTRACTUAL ALLOW	22,322.13
NON-COVERD CHARGES	1,566.00	TOTAL MEDICAID LIAB	13,956.87
		LESS: COB	13,956.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 19

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,524.00	25.00	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	846.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,135.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,550.00	526.00
EKG/ECG	0.00	0.00	MRI SERVICES	4,308.00	0.00
IV THERAPY	1,367.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,367.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,015.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	36,279.00	1,566.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,279.00	1,566.00

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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EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	575,482.00	ADJUSTMENTS	161.82
COVERED CHARGES	559,542.00	CONTRACTUAL ALLOW	544,102.56
NON-COVERD CHARGES	15,940.00	TOTAL MEDICAID LIAB	15,439.44
		LESS: COB	0.00
		LESS: COPAYMENT	498.00
		REIMBURSEMENT	14,941.44
		TOTAL NUMBER OF CLAIMS	276

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,768.00	1,383.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,598.00	208.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,004.00	1,894.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	73,514.00	5,879.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	98,503.00	2,826.00
EKG/ECG	4,405.00	0.00	MRI SERVICES	4,868.00	0.00
IV THERAPY	33,281.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,707.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,566.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	248,990.00	955.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,281.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	659.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,605.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,452.00	2,136.00			
			TOTAL ANCILLARY	559,542.00	15,940.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	559,542.00	15,940.00

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

EMANUEL MEDICAL CENTER
 117 KITE RD
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
 000000701A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,534.00	ADJUSTMENTS	0.00
COVERED CHARGES	20,233.00	CONTRACTUAL ALLOW	11,149.02
NON-COVERD CHARGES	3,301.00	TOTAL MEDICAID LIAB	9,083.98
		LESS: COB	9,068.98
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,066.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	167.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,170.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,476.00	2,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,999.00	99.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,143.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,212.00	595.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,233.00	3,301.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,233.00	3,301.00

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

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

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

EMANUEL MEDICAL CENTER
117 KITE RD
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER
000000701A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/29/2018
Run Time: 00:32:49
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	552,676.00	ADJUSTMENTS	0.00
COVERED CHARGES	517,771.00	CONTRACTUAL ALLOW	309,195.13
NON-COVERD CHARGES	34,905.00	TOTAL MEDICAID LIAB	208,575.87
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	208,575.87

TOTAL NUMBER OF ADMISSIONS 29

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	51		0	56,763.00		7,266.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	51		0	56,763.00		7,266.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	23		0	36,225.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	36,225.00		0.00
TOTAL ACCOMODATIONS	74		0	92,988.00		7,266.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,180.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50,260.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	150,761.00	0.00	EDUCATION & TRAINING	1,075.00	0.00
RADIOLOGY-DIAGNOSTIC	11,648.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,929.00	8,745.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	704.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,162.00	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	22,898.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,652.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,138.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,750.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,129.00
OTHER IMAGING SERVICE	1,574.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,495.00	7,658.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,151.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,058.00	3,455.00			
			TOTAL ANCILLARY	424,783.00	27,639.00
			TOTAL ACCOMODATIONS	92,988.00	7,266.00
			TOTAL CHARGES	517,771.00	34,905.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
76	2217104014495	03/22/17 - 03/23/17	04/17/17	0.00	2,129.00	0.00	0.00	0.00
TOTAL				0.00	2,129.00	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

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 10/01/16 THROUGH 09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,657,819.90	ADJUSTMENTS	23,411.56
COVERED CHARGES	1,540,443.90	CONTRACTUAL ALLOW	1,233,706.80
NON-COVERD CHARGES	117,376.00	TOTAL MEDICAID LIAB	306,737.10
		LESS: COB	94.72
		LESS: COPAYMENT	1,209.00
		REIMBURSEMENT	305,433.38
		ALL OTHER	279,774.60
		FEE SCHEDULE-LAB	21,809.30
		INJECTABLE DRUGS	3,849.48

TOTAL NUMBER OF CLAIMS 965

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,798.00	0.00	OTHER LAB	5,559.00	0.00
MED/SURG SUPPLY	52,614.90	68.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	200.00
RADIOLOGY-DIAGNOSTIC	88,575.00	5,412.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	247,064.00	34,131.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,532.00	4,509.00	FEE SCHEDULE LAB	367,815.00	13,827.00
EKG/ECG	21,991.00	932.00	MRI SERVICES	89,755.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	100.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,697.00	142.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,322.00	23,791.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	379,256.00	15,478.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,645.00	1,551.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	12,910.00
OTHER IMAGING SERVICE	22,820.00	2,540.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,564.00	1,297.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,224.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,212.00	488.00			
			TOTAL ANCILLARY	1,540,443.90	117,376.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,540,443.90	117,376.00

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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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
45	2217068005173	03/01/17 - 03/01/17	03/13/17	0.00	179.00	0.00	0.00	0.00
41	2217156006607	05/17/17 - 05/17/17	06/12/17	0.00	68.00	0.00	0.00	0.00
685	2217209017140	07/04/17 - 07/04/17	07/31/17	0.00	4,909.00	0.00	0.00	0.00
615	2217242004777	08/24/17 - 08/24/17	09/04/17	0.00	3,877.00	0.00	0.00	0.00
615	2217242004777	08/24/17 - 08/24/17	09/04/17	0.00	3,877.00	0.00	0.00	0.00
TOTAL				0.00	12,910.00	0.00	0.00	0.00

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST
CLAXTON,GA 30417-1659

PROVIDER NUMBER
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,717.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,282.00	CONTRACTUAL ALLOW	2,258.01
NON-COVERD CHARGES	12,435.00	TOTAL MEDICAID LIAB	2,023.99
		LESS: COB	2,020.99
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	329.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,596.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	1,114.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,264.00	116.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	11,178.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	952.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	141.00	27.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,282.00	12,435.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,282.00	12,435.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	162,016.00	ADJUSTMENTS	55.94
COVERED CHARGES	157,715.00	CONTRACTUAL ALLOW	149,268.06
NON-COVERD CHARGES	4,301.00	TOTAL MEDICAID LIAB	8,446.94
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	8,173.94
		TOTAL NUMBER OF CLAIMS	151

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,564.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,543.00	28.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,001.00	416.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,260.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,184.00	0.00	FEE SCHEDULE LAB	19,949.00	2,196.00
EKG/ECG	1,183.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	524.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	101,737.00	1,607.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,770.00	54.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	157,715.00	4,301.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	157,715.00	4,301.00

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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,720.50	ADJUSTMENTS	0.00
COVERED CHARGES	25,862.50	CONTRACTUAL ALLOW	20,421.90
NON-COVERD CHARGES	858.00	TOTAL MEDICAID LIAB	5,440.60
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,437.60

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,965.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	762.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	240.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,000.00	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	437.00	96.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,862.50	858.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,862.50	858.00

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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
 304 TURNER MCCALL BLVD SW
 ROME,GA 30165-5621

PROVIDER NUMBER 000000756A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,137,259.58	ADJUSTMENTS	3,237,259.74
COVERED CHARGES	64,738,326.48	CONTRACTUAL ALLOW	49,249,409.42
NON-COVERD CHARGES	2,398,933.10	TOTAL MEDICAID LIAB	15,488,917.06
		LESS: COB	66,984.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,421,932.97

TOTAL NUMBER OF ADMISSIONS 1,771

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,628		0	3,006,850.00		648,340.00
ROUTINE NURSERY	928		0	859,600.00		19,525.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,556		0	3,866,450.00		667,865.00
SPECIAL CARE SERVICES						
CCU	1,104		0	858,000.00		61,875.00
ICU	1,852		0	2,380,125.00		36,300.00
NICU	550		0	1,195,382.50		0.00
PED ICU	10		0	12,100.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,516		0	4,445,607.50		98,175.00
TOTAL ACCOMODATIONS	10,072		0	8,312,057.50		766,040.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,373,604.15	42,256.25	OTHER LAB	429,863.00	0.00
MED/SURG SUPPLY	5,009,844.09	134,439.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,652,135.50	172,147.00	EDUCATION & TRAINING	8,468.00	32.00
RADIOLOGY-DIAGNOSTIC	972,708.00	7,563.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,811,821.00	34,617.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	108,929.00	3,268.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,170,870.00	46,063.00	MRI SERVICES	514,512.00	3,430.00
IV THERAPY	351,679.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,339,390.40	75,177.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	964,946.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,591,590.00	241,191.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	834,163.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,643,484.00	4,249.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	615,578.00	757.00	DRUG-SPECIFIC/HOME IV	0.00	140,350.00
LABORATORY PATHOLOGIC	255,897.00	0.00	INJECTABLE DRUGS	4,274,564.29	311,693.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	50,529.00	304.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	63,930.00	1,085.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	251,914.00	82,204.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,336.00	9,922.00	TRAUMA RESPONSE	0.00	46,776.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,310,016.55	2,971.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	192,973.00	35,100.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	272,143.00	154,070.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	201,499.00	52,636.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,960,333.00	13,077.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,704.00	739.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	138,845.00	16,775.00			
			TOTAL ANCILLARY	56,426,268.98	1,632,893.10
			TOTAL ACCOMODATIONS	8,312,057.50	766,040.00
			TOTAL CHARGES	64,738,326.48	2,398,933.10

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	696,809.79	ADJUSTMENTS	0.00
COVERED CHARGES	692,788.79	CONTRACTUAL ALLOW	384,476.22
NON-COVERD CHARGES	4,021.00	TOTAL MEDICAID LIAB	308,312.57
		LESS: COB	308,312.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	78		0	42,900.00		2,695.00
ROUTINE NURSERY	6		0	6,900.00		781.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	84		0	49,800.00		3,476.00
SPECIAL CARE SERVICES						
CCU	2		0	1,650.00		0.00
ICU	5		0	8,250.00		0.00
NICU	1		0	2,152.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	12,052.00		0.00
TOTAL ACCOMODATIONS	92		0	61,852.00		3,476.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,439.25	0.00	OTHER LAB	6,720.00	0.00
MED/SURG SUPPLY	53,188.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	80,714.00	0.00	EDUCATION & TRAINING	32.00	0.00
RADIOLOGY-DIAGNOSTIC	7,415.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	714.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,843.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,213.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	187,336.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	62,560.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,399.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,673.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,014.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,758.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,434.00	0.00	INJECTABLE DRUGS	8,008.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	468.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	7,181.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,883.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,403.00	545.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,205.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,890.00	0.00			
			TOTAL ANCILLARY	630,936.79	545.00
			TOTAL ACCOMODATIONS	61,852.00	3,476.00
			TOTAL CHARGES	692,788.79	4,021.00

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: 08/29/2018
Run Time: 00:11:03
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,847,775.10	ADJUSTMENTS	1,692,830.50
COVERED CHARGES	43,590,835.79	CONTRACTUAL ALLOW	37,107,093.16
NON-COVERD CHARGES	2,256,939.31	TOTAL MEDICAID LIAB	6,483,742.63
		LESS: COB	11,539.45
		LESS: COPAYMENT	14,394.00
		REIMBURSEMENT	6,457,809.18
		ALL OTHER	5,866,311.29
		FEE SCHEDULE-LAB	539,364.40
		INJECTABLE DRUGS	52,133.49

TOTAL NUMBER OF CLAIMS 13,005

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,428,312.10	5,078.75	OTHER LAB	190,311.00	2,400.00
MED/SURG SUPPLY	2,071,161.11	33,285.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	469.00	EDUCATION & TRAINING	9,119.00	1,184.00
RADIOLOGY-DIAGNOSTIC	1,422,846.00	18,923.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,227,940.00	105,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	134,325.00	31,986.06	FEE SCHEDULE LAB	7,884,270.60	267,633.00
EKG/ECG	821,782.00	8,217.00	MRI SERVICES	691,954.00	67,634.00
IV THERAPY	2,873,112.00	176,368.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,137,473.00	368,345.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	99,221.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	133,400.00	366,229.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	584,678.00	4,960.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	9,900.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,614,779.98	382,369.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	595,246.00	482.00	DRUG-SPECIFIC/HOME IV	0.00	16,590.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	298,071.50	10,702.50
RADIOLOGY THERAPEUTIC	9,900.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,344.00	4,573.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,660.00	2,128.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	61,624.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	463,973.00	15,687.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	234,086.50	2,347.00
LITHOTRIPSY	97,044.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	402,811.00	28,506.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69,275.00	24,525.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	710,627.00	77,350.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	856,460.00	125,603.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	203,080.00	704.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,319,573.00	35,373.00			
			TOTAL ANCILLARY	43,590,835.79	2,256,939.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,590,835.79	2,256,939.31

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: 08/29/2018
Run Time: 00:12:12
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	748,832.23	ADJUSTMENTS	0.00
COVERED CHARGES	589,645.23	CONTRACTUAL ALLOW	254,665.34
NON-COVERD CHARGES	159,187.00	TOTAL MEDICAID LIAB	334,979.89
		LESS: COB	334,923.35
		LESS: COPAYMENT	56.54
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 149

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,312.75	0.00	OTHER LAB	4,800.00	0.00
MED/SURG SUPPLY	27,855.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	240.00	0.00
RADIOLOGY-DIAGNOSTIC	17,126.00	589.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,251.00	41,860.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,038.00	76.00	FEE SCHEDULE LAB	121,154.98	2,317.00
EKG/ECG	6,428.00	0.00	MRI SERVICES	2,497.00	1,548.00
IV THERAPY	23,102.00	850.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,100.00	102,578.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,918.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,390.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	160,487.00	2,536.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,487.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,084.50	816.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	719.00	315.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,588.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,628.00	2,833.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,438.00	545.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,141.00	79.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,413.00	2,245.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	739.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,390.00	0.00			
			TOTAL ANCILLARY	589,645.23	159,187.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	589,645.23	159,187.00

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: 08/29/2018
Run Time: 00:12:14
Page: 9

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	915,179.25	ADJUSTMENTS	2,300.42
COVERED CHARGES	898,596.25	CONTRACTUAL ALLOW	877,339.05
NON-COVERD CHARGES	16,583.00	TOTAL MEDICAID LIAB	21,257.20
		LESS: COB	0.00
		LESS: COPAYMENT	861.00
		REIMBURSEMENT	20,396.20
		TOTAL NUMBER OF CLAIMS	380

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,996.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,250.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	32.00	0.00
RADIOLOGY-DIAGNOSTIC	60,999.00	776.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,152.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	157,450.00	6,829.00
EKG/ECG	6,973.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,469.00	1,908.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.00	571.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	513,031.00	4,355.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,883.50	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	250.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	98.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,635.00	790.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,400.00	1,104.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,909.00	0.00			
			TOTAL ANCILLARY	898,596.25	16,583.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	898,596.25	16,583.00

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: 08/29/2018
Run Time: 00:12:18
Page: 11

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,037.25	ADJUSTMENTS	0.00
COVERED CHARGES	68,637.25	CONTRACTUAL ALLOW	40,582.02
NON-COVERD CHARGES	6,400.00	TOTAL MEDICAID LIAB	28,055.23
		LESS: COB	28,040.23
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,229.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,707.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,667.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,790.00	5,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,152.00	548.00
EKG/ECG	1,011.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,014.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,764.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	266.50	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	49.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	567.00	652.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,420.00	0.00			
			TOTAL ANCILLARY	68,637.25	6,400.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,637.25	6,400.00

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: 08/29/2018
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,007,058.27	ADJUSTMENTS	198,711.95
COVERED CHARGES	5,873,118.27	CONTRACTUAL ALLOW	5,187,550.16
NON-COVERD CHARGES	133,940.00	TOTAL MEDICAID LIAB	685,568.11
		LESS: COB	3,005.95
		LESS: COPAYMENT	636.00
		REIMBURSEMENT	681,926.16

TOTAL NUMBER OF CLAIMS 121

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,969,425.55	0.00	OTHER LAB	21,708.00	0.00
MED/SURG SUPPLY	346,616.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	256.00	64.00
RADIOLOGY-DIAGNOSTIC	17,935.00	4,375.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,292.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	153,405.00	5,600.00
EKG/ECG	22,679.00	1,348.00	MRI SERVICES	16,796.00	0.00
IV THERAPY	396,766.00	22,322.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,655,902.00	52,992.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,647.00	20,124.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	201,384.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	60,984.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	135,078.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,555.00	0.00
RADIOLOGY THERAPEUTIC	126.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,243.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	696.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	489,630.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,246.00	1,790.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,962.00	1,635.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,863.00	2,360.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	166,282.00	18,897.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	739.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	102,145.00	1,190.00			
			TOTAL ANCILLARY	5,873,118.27	133,940.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,873,118.27	133,940.00

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: 08/29/2018
Run Time: 00:12:22
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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY
 6135 ROOSEVELT HWY
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,690,895.17	ADJUSTMENTS	1,318,467.20
COVERED CHARGES	4,636,082.17	CONTRACTUAL ALLOW	2,238,364.66
NON-COVERD CHARGES	54,813.00	TOTAL MEDICAID LIAB	2,397,717.51
		LESS: COB	15,915.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,381,801.97

TOTAL NUMBER OF ADMISSIONS 92

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,514		0	2,023,650.00		20,250.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,514		0	2,023,650.00		20,250.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,514		0	2,023,650.00		20,250.00

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	436,307.43	2,263.00	OTHER LAB	1,103.00	0.00
MED/SURG SUPPLY	97,227.00	2,987.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	156,721.00	3,461.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,928.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	805,206.34	8,554.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,388.00	155.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,383.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,771.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,076.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	863,666.32	9,575.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	162,335.08	4,776.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	22,320.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	1,570.00			
BLOOD STORAGE & PRO.	0.00	1,222.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,612,432.17	34,563.00
			TOTAL ACCOMODATIONS	2,023,650.00	20,250.00
			TOTAL CHARGES	4,636,082.17	54,813.00

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/16 THROUGH 06/30/17
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 07/01/16 THROUGH 06/30/17
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 07/01/16 THROUGH 06/30/17
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
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SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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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	07/01/16	THROUGH	06/30/17
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	07/01/16	THROUGH	06/30/17
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	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
6135 ROOSEVELT HWY	000000778A	SERVICE DATES	07/01/16	THROUGH	06/30/17
WARM SPRINGS,GA 31830-2757		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

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	07/01/16	THROUGH	06/30/17
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
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	230,211,218.53	ADJUSTMENTS	9,905,194.07
COVERED CHARGES	222,822,846.98	CONTRACTUAL ALLOW	190,518,138.15
NON-COVERD CHARGES	7,388,371.55	TOTAL MEDICAID LIAB	32,304,708.83
		LESS: COB	454,734.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	31,849,974.08

TOTAL NUMBER OF ADMISSIONS 3,526

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,729		0	17,451,484.00		876,178.60
ROUTINE NURSERY	1,672		0	2,590,113.70		10,667.10
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12,401		0	20,041,597.70		886,845.70
SPECIAL CARE SERVICES						
CCU	110		0	483,120.00		0.00
ICU	8,505		0	27,986,280.77		271,404.43
NICU	317		0	1,267,348.00		16,012.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		48	0.00		129,216.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8,932		48	29,736,748.77		416,632.43
TOTAL ACCOMODATIONS	21,333		48	49,778,346.47		1,303,478.13

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,888,273.12	689,878.08	OTHER LAB	598,519.02	3,439.22
MED/SURG SUPPLY	11,920,649.82	451,170.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,381,935.28	221,918.09	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,086,598.26	18,040.99	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,983,307.28	38,254.03	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,434,234.18	68,923.43	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	740,796.34	1,177.17	MRI SERVICES	2,431,900.15	4,975.35
IV THERAPY	3,770.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,151,751.76	188,041.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,639,573.72	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,883,091.56	88,161.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,881,716.99	53,118.69	AMBULANCE	0.00	0.00
GI SERVICES	520,645.89	3,128.78	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,884,503.97	35,267.48	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,984,161.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	842,822.53	8,093.45	INJECTABLE DRUGS	0.00	137,340.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	852,253.69	26,457.71	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	608,545.86	5,332.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,332,814.18	80,787.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	42,668.46	367.02	TRAUMA RESPONSE	0.00	1,996,200.60
PSYCHIATRIC SERVICES	835,693.29	0.00	IMPL DEV CHARGE PATIENTS	5,994,544.62	124,259.19
LITHOTRIpsy	243,000.59	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,001,418.63	10,938.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	126,333.07	1,811,491.89			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,268,635.57	4,131.70			
AUDIOLOGY	91,704.35	0.00			
CARDIOLOGY	3,919,468.30	13,917.35			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	342,479.93	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,688.58	81.93			
			TOTAL ANCILLARY	173,044,500.51	6,084,893.42
			TOTAL ACCOMODATIONS	49,778,346.47	1,303,478.13
			TOTAL CHARGES	222,822,846.98	7,388,371.55

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	190,686.44	ADJUSTMENTS	0.00
COVERED CHARGES	164,922.86	CONTRACTUAL ALLOW	83,675.45
NON-COVERD CHARGES	25,763.58	TOTAL MEDICAID LIAB	81,247.41
		LESS: COB	81,247.41
		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	11		0	17,974.00		671.00
ROUTINE NURSERY	2		0	2,242.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13		0	20,216.00		671.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	4,392.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	4,392.00		0.00
TOTAL ACCOMODATIONS	14		0	24,608.00		671.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,316.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,273.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,940.42	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,030.27	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,341.68	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,683.81	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	22,067.71	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,385.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,958.22	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,578.91	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,326.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,130.48	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	996.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	24,322.80
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	769.78			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	286.22	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	140,314.86	25,092.58
			TOTAL ACCOMODATIONS	24,608.00	671.00
			TOTAL CHARGES	164,922.86	25,763.58

Report : CLM-0804-0
Process : CLMJ0800
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
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,773,646.10	ADJUSTMENTS	644,272.11
COVERED CHARGES	60,641,224.17	CONTRACTUAL ALLOW	56,054,789.63
NON-COVERD CHARGES	4,132,421.93	TOTAL MEDICAID LIAB	4,586,434.54
		LESS: COB	3,410.17
		LESS: COPAYMENT	7,731.34
		REIMBURSEMENT	4,575,293.03
		ALL OTHER	4,153,672.58
		FEE SCHEDULE-LAB	353,911.84
		INJECTABLE DRUGS	67,708.61
		TOTAL NUMBER OF CLAIMS	13,152

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,921,893.36	26,311.74	OTHER LAB	319,180.30	0.00
MED/SURG SUPPLY	2,721,047.50	678.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,969,061.71	68,248.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,455,849.37	592,290.97	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	28,763.79	25,871.62	FEE SCHEDULE LAB	7,464,293.56	54,290.02
EKG/ECG	796,766.70	6,278.24	MRI SERVICES	1,092,986.94	79,107.12
IV THERAPY	2,831,634.65	14,217.54	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,618,119.33	719,532.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,850.41	23,731.79	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,136,244.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	208,850.48	31,786.27	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,446,009.00	36,684.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	536,907.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,332.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,970,732.83	689,777.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,229.34	12,172.53	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,831.57	3,619.49	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	54,242.70	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	79,467.59	17,622.58	TRAUMA RESPONSE	0.00	866,197.44
PSYCHIATRIC SERVICES	426,371.81	476.65	IMPL DEV CHARGE PATIENTS	375,692.40	27,510.62
LITHOTRIPSY	1,041,431.10	104,143.11	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,578,453.99	293,716.43			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,141.46	100,469.18			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	617,111.49	58,239.72			
AUDIOLOGY	24,591.53	3,248.82			
CARDIOLOGY	449,956.18	166,032.04			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	728,736.83	6,965.03			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	680,016.45	43,626.88			
			TOTAL ANCILLARY	60,641,224.17	4,132,421.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,641,224.17	4,132,421.93

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,932.73	ADJUSTMENTS	0.00
COVERED CHARGES	55,881.77	CONTRACTUAL ALLOW	46,706.74
NON-COVERD CHARGES	11,050.96	TOTAL MEDICAID LIAB	9,175.03
		LESS: COB	9,164.53
		LESS: COPAYMENT	10.50
		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

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA,GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,578.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,568.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	646.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,698.36	5,979.43	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,544.34	0.00
EKG/ECG	784.78	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,152.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,684.51	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,429.87	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,573.04	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,221.17	4,327.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	744.41			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	55,881.77	11,050.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	55,881.77	11,050.96

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: 08/29/2018
Run Time: 00:34:11
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,504,883.19	ADJUSTMENTS	856.04
COVERED CHARGES	4,385,653.18	CONTRACTUAL ALLOW	4,290,107.66
NON-COVERD CHARGES	119,230.01	TOTAL MEDICAID LIAB	95,545.52
		LESS: COB	0.00
		LESS: COPAYMENT	3,692.05
		REIMBURSEMENT	91,853.47
		TOTAL NUMBER OF CLAIMS	1,708

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164,063.34	337.29	OTHER LAB	10,352.32	0.00
MED/SURG SUPPLY	67,009.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	244,125.56	6,362.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	515,524.51	10,183.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	767,480.73	7,177.62
EKG/ECG	44,340.07	392.39	MRI SERVICES	38,264.43	19,006.98
IV THERAPY	276,313.05	438.56	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,262.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,159.74	1,057.16	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,478.53	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,875,819.15	764.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,816.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	185,225.55	19,894.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	327.72	TRAUMA RESPONSE	0.00	20,577.72
PSYCHIATRIC SERVICES	13,911.66	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	156,013.97	32,709.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,493.10	0.00			
			TOTAL ANCILLARY	4,385,653.18	119,230.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,385,653.18	119,230.01

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

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

Run Date: 08/29/2018
Run Time: 00:34:16
Page: 11

WELLSTAR ATLANTA MEDICAL CENTER, INC
303 PARKWAY DRIVE, NE
ATLANTA,GA 30312-1212

PROVIDER NUMBER
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,052.59	ADJUSTMENTS	0.00
COVERED CHARGES	3,739.20	CONTRACTUAL ALLOW	3,514.20
NON-COVERD CHARGES	1,313.39	TOTAL MEDICAID LIAB	225.00
		LESS: COB	225.00
		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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	1,663.07	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,957.36	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	118.77	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,313.39			
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	0.00	0.00			
			TOTAL ANCILLARY	3,739.20	1,313.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,739.20	1,313.39

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,704,908.54	ADJUSTMENTS	18,392.58
COVERED CHARGES	1,625,888.93	CONTRACTUAL ALLOW	1,540,000.89
NON-COVERD CHARGES	79,019.61	TOTAL MEDICAID LIAB	85,888.04
		LESS: COB	0.00
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	85,822.04
		TOTAL NUMBER OF CLAIMS	14

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

WELLSTAR ATLANTA MEDICAL CENTER, INC
 303 PARKWAY DRIVE, NE
 ATLANTA, GA 30312-1212

PROVIDER NUMBER
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,076.32	293.15	OTHER LAB	1,719.61	0.00
MED/SURG SUPPLY	167,222.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,511.61	1,592.66	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,904.16	0.00
EKG/ECG	1,569.56	392.39	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	401,627.61	33,737.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,949.38	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,369.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,143.79	43,003.97
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	799,735.67	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	66,141.86	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	13,917.24	0.00			
			TOTAL ANCILLARY	1,625,888.93	79,019.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,625,888.93	79,019.61

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: 08/29/2018
Run Time: 00:34:19
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:40:40
 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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,100,001.17	ADJUSTMENTS	55,298.38
COVERED CHARGES	2,079,491.17	CONTRACTUAL ALLOW	1,300,481.49
NON-COVERD CHARGES	20,510.00	TOTAL MEDICAID LIAB	779,009.68
		LESS: COB	11,710.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	767,298.90

TOTAL NUMBER OF ADMISSIONS 117

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	374		0	388,586.00		16,796.00
ROUTINE NURSERY	37		0	35,039.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	411		0	423,625.00		16,796.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	59		0	124,018.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	59		0	124,018.00		0.00
TOTAL ACCOMODATIONS	470		0	547,643.00		16,796.00

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	418,175.86	0.00	OTHER LAB	9,267.00	0.00
MED/SURG SUPPLY	183,375.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	203,049.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,149.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	72,294.00	1,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,997.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,425.00	0.00	MRI SERVICES	20,689.00	0.00
IV THERAPY	50,726.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	180,924.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,816.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77,331.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,564.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,127.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	7,519.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	508.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	577.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,465.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,577.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,707.00	2,246.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,288.00	0.00			
AUDIOLOGY	4,074.00	0.00			
CARDIOLOGY	28,432.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,471.00	0.00			
			TOTAL ANCILLARY	1,531,848.17	3,714.00
			TOTAL ACCOMODATIONS	547,643.00	16,796.00
			TOTAL CHARGES	2,079,491.17	20,510.00

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

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

Run Date: 08/29/2018
 Run Time: 00:40:41
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	146,744.60	ADJUSTMENTS	0.00
COVERED CHARGES	144,186.60	CONTRACTUAL ALLOW	51,131.51
NON-COVERD CHARGES	2,558.00	TOTAL MEDICAID LIAB	93,055.09
		LESS: COB	93,055.09
		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	49		0	50,911.00		2,558.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	49		0	50,911.00		2,558.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	49		0	50,911.00		2,558.00

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,198.60	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	3,744.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,122.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	765.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,870.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	198.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	290.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,119.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,594.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,722.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,905.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,016.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,181.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,851.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	462.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,776.00	0.00			
			TOTAL ANCILLARY	93,275.60	0.00
			TOTAL ACCOMODATIONS	50,911.00	2,558.00
			TOTAL CHARGES	144,186.60	2,558.00

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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,716,990.46	ADJUSTMENTS	75,042.67
COVERED CHARGES	2,522,390.27	CONTRACTUAL ALLOW	1,830,524.98
NON-COVERD CHARGES	194,600.19	TOTAL MEDICAID LIAB	691,865.29
		LESS: COB	1,549.30
		LESS: COPAYMENT	2,202.00
		REIMBURSEMENT	688,113.99
		ALL OTHER	500,909.72
		FEE SCHEDULE-LAB	73,296.90
		INJECTABLE DRUGS	113,907.37

TOTAL NUMBER OF CLAIMS 2,157

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,217.09	2,070.70	OTHER LAB	31,401.00	16,164.00
MED/SURG SUPPLY	74,690.89	0.00	RECREATIONAL THERAPY	369.00	0.00
LABORATORY-GENERAL	0.00	204.00	EDUCATION & TRAINING	136.00	306.00
RADIOLOGY-DIAGNOSTIC	134,420.00	4,550.00	OTHER THERAPEUTIC SVC	0.00	2,093.00
CT SCAN	276,207.00	24,323.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,179.00	3,541.02	FEE SCHEDULE LAB	373,726.63	25,127.13
EKG/ECG	27,497.00	435.00	MRI SERVICES	114,404.00	3,550.00
IV THERAPY	130,192.00	6,072.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,125.83	15,298.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,826.00	1,243.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,913.00	9,941.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,404.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	541,898.00	10,296.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,433.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	294,460.83	42,706.15
RADIOLOGY THERAPEUTIC	88,950.00	10,500.00	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	2,352.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	93,521.00	6,190.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,504.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,781.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,464.00	3,200.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	550.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,768.00	6,790.00			
			TOTAL ANCILLARY	2,522,390.27	194,600.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,522,390.27	194,600.19

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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,371.78	ADJUSTMENTS	0.00
COVERED CHARGES	61,539.28	CONTRACTUAL ALLOW	30,970.05
NON-COVERD CHARGES	17,832.50	TOTAL MEDICAID LIAB	30,569.23
		LESS: COB	30,542.23
		LESS: COPAYMENT	27.00
		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

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,017.34	0.00	OTHER LAB	420.00	0.00
MED/SURG SUPPLY	3,474.70	0.00	RECREATIONAL THERAPY	492.00	246.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,797.00	426.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,989.00	8,998.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,997.00	864.00
EKG/ECG	435.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,007.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,928.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	235.00	168.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,597.00	576.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,350.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,442.00	492.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	424.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,355.24	4,135.50
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	755.00	1,927.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	550.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	274.00	0.00			
			TOTAL ANCILLARY	61,539.28	17,832.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,539.28	17,832.50

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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	168,051.30	ADJUSTMENTS	373.58
COVERED CHARGES	159,925.15	CONTRACTUAL ALLOW	148,513.39
NON-COVERD CHARGES	8,126.15	TOTAL MEDICAID LIAB	11,411.76
		LESS: COB	0.00
		LESS: COPAYMENT	346.28
		REIMBURSEMENT	11,065.48
		TOTAL NUMBER OF CLAIMS	204

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,411.86	221.80	OTHER LAB	801.00	0.00
MED/SURG SUPPLY	491.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,988.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,435.00	3,524.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,235.00	2,176.00
EKG/ECG	1,160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,304.00	332.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	612.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	86,365.00	123.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,531.95	1,749.35
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	755.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,779.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,056.00	0.00			
			TOTAL ANCILLARY	159,925.15	8,126.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	159,925.15	8,126.15

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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,278.50	ADJUSTMENTS	0.00
COVERED CHARGES	6,210.30	CONTRACTUAL ALLOW	4,372.84
NON-COVERD CHARGES	68.20	TOTAL MEDICAID LIAB	1,837.46
		LESS: COB	1,828.46
		LESS: COPAYMENT	9.00
		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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.70	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	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	2,065.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,179.00	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	209.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,111.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108.60	36.20
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	6,210.30	68.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,210.30	68.20

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

Run Date: 08/29/2018
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Page: 13

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	164,334.47	ADJUSTMENTS	17,925.42
COVERED CHARGES	161,059.87	CONTRACTUAL ALLOW	83,344.05
NON-COVERD CHARGES	3,274.60	TOTAL MEDICAID LIAB	77,715.82
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	77,667.82

TOTAL NUMBER OF CLAIMS 13

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,371.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	527.08	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	492.00
CT SCAN	975.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,136.00	0.00
EKG/ECG	290.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,820.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	686.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	137,060.29	2,659.60
RADIOLOGY THERAPEUTIC	99.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	132.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,963.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	123.00			
			TOTAL ANCILLARY	161,059.87	3,274.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	161,059.87	3,274.60

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

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

Run Date: 08/29/2018
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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	05/01/16	THROUGH	04/30/17
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: 08/29/2018
 Run Time: 00:34:43
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL
 1155 5TH ST SE
 CAIRO,GA 39828-3142

PROVIDER NUMBER 000000844A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,060,538.30	ADJUSTMENTS	242,711.52
COVERED CHARGES	2,048,793.30	CONTRACTUAL ALLOW	1,089,579.76
NON-COVERD CHARGES	11,745.00	TOTAL MEDICAID LIAB	959,213.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	959,213.54

TOTAL NUMBER OF ADMISSIONS 209

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	391		0	239,372.00		9,578.00
ROUTINE NURSERY	137		0	70,144.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	528		0	309,516.00		9,578.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	41		0	61,623.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	61,623.00		0.00
TOTAL ACCOMODATIONS	569		0	371,139.00		9,578.00

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

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

Run Date: 08/29/2018
 Run Time: 00:34:43
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL
 1155 5TH ST SE
 CAIRO,GA 39828-3142

PROVIDER NUMBER
 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	424,419.20	0.00	OTHER LAB	2,150.00	0.00
MED/SURG SUPPLY	162,907.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	328,745.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,905.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,024.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,173.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,319.00	0.00	MRI SERVICES	11,349.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	187,568.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	155,372.00	291.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,802.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,348.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,675.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,994.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,100.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,669.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,247.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,254.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,244.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,314.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,568.00	1,876.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	30,175.00	0.00			
CARDIOLOGY	19,085.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,248.00	0.00			
			TOTAL ANCILLARY	1,677,654.30	2,167.00
			TOTAL ACCOMODATIONS	371,139.00	9,578.00
			TOTAL CHARGES	2,048,793.30	11,745.00

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

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 10/01/16 THROUGH 09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,583,119.74	ADJUSTMENTS	33,328.99
COVERED CHARGES	2,381,875.78	CONTRACTUAL ALLOW	1,851,708.36
NON-COVERD CHARGES	201,243.96	TOTAL MEDICAID LIAB	530,167.42
		LESS: COB	875.96
		LESS: COPAYMENT	1,638.00
		REIMBURSEMENT	527,653.46
		ALL OTHER	451,557.72
		FEE SCHEDULE-LAB	67,464.22
		INJECTABLE DRUGS	8,631.52

TOTAL NUMBER OF CLAIMS 2,030

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,090.00	3,435.00	OTHER LAB	11,543.00	0.00
MED/SURG SUPPLY	124,248.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	164,623.00	6,464.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	300,748.00	30,137.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,644.00	28,779.00	FEE SCHEDULE LAB	505,129.37	16,799.00
EKG/ECG	27,921.00	0.00	MRI SERVICES	20,143.00	1,881.00
IV THERAPY	155,448.00	904.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	234,969.21	42,250.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,896.00	308.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,838.00	8,463.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,150.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	59,195.00	6,995.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	315,917.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,916.00	10,577.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78,302.20	17,471.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,137.00	15,010.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,430.07	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,199.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,862.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	53,863.00	7,122.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,921.00	504.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,596.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,776.00	1,515.00			
			TOTAL ANCILLARY	2,381,875.78	201,243.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,381,875.78	201,243.96

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: 08/29/2018
Run Time: 00:34:50
Page: 6

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,405.50	ADJUSTMENTS	0.00
COVERED CHARGES	26,010.00	CONTRACTUAL ALLOW	5,940.16
NON-COVERD CHARGES	10,395.50	TOTAL MEDICAID LIAB	20,069.84
		LESS: COB	20,037.47
		LESS: COPAYMENT	32.37
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	192.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,174.00	270.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,559.00	5,099.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,859.00	0.00	FEE SCHEDULE LAB	1,137.00	684.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	2,385.00
IV THERAPY	356.00	113.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,334.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,418.00	95.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	951.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,120.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,412.00	156.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,216.00	642.00			
			TOTAL ANCILLARY	26,010.00	10,395.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,010.00	10,395.50

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,794.00	ADJUSTMENTS	55.94
COVERED CHARGES	72,504.00	CONTRACTUAL ALLOW	67,021.88
NON-COVERD CHARGES	2,290.00	TOTAL MEDICAID LIAB	5,482.12
		LESS: COB	0.00
		LESS: COPAYMENT	115.97
		REIMBURSEMENT	5,366.15
		TOTAL NUMBER OF CLAIMS	98

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	361.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,502.00	316.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,251.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,310.00	1,934.00
EKG/ECG	1,062.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,181.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,314.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,442.00	40.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,504.00	2,290.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,504.00	2,290.00

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,578.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,207.00	CONTRACTUAL ALLOW	4,051.95
NON-COVERD CHARGES	371.00	TOTAL MEDICAID LIAB	155.05
		LESS: COB	152.05
		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: 08/29/2018
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GENERAL HOSPITAL
 1155 5TH ST SE
 CAIRO,GA 39828-3142

PROVIDER NUMBER
 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	88.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,048.00	371.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,059.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	883.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,207.00	371.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,207.00	371.00

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 GENERAL HOSPITAL
1155 5TH ST SE
CAIRO,GA 39828-3142

PROVIDER NUMBER
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	92,002.00	ADJUSTMENTS	0.00
COVERED CHARGES	78,397.00	CONTRACTUAL ALLOW	61,761.31
NON-COVERD CHARGES	13,605.00	TOTAL MEDICAID LIAB	16,635.69
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	16,608.69

TOTAL NUMBER OF CLAIMS 3

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,925.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,916.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	652.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,618.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,094.00	3,277.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,137.00	6,646.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,772.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,525.00	3,682.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,081.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,397.00	13,605.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,397.00	13,605.00

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: 08/29/2018
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Page: 14

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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	548,230,521.26	ADJUSTMENTS	24,123,687.32
COVERED CHARGES	525,007,479.92	CONTRACTUAL ALLOW	413,948,255.39
NON-COVERD CHARGES	23,223,041.34	TOTAL MEDICAID LIAB	111,059,224.53
		LESS: COB	354,717.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	110,704,506.70

TOTAL NUMBER OF ADMISSIONS 7,372

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	31,643		0	53,716,729.00		3,405,859.00
ROUTINE NURSERY	4,870		0	9,694,967.00		1,368,581.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		315,185.44
TOTAL ROUTINE	36,513		0	63,411,696.00		5,089,625.44
SPECIAL CARE SERVICES						
CCU	474		0	1,389,018.00		93,750.00
ICU	14,265		0	53,133,502.79		2,673,945.21
NICU	627		0	3,084,172.41		235,905.09
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	905		0	6,444,132.00		571,480.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	16,271		0	64,050,825.20		3,575,080.30
TOTAL ACCOMODATIONS	52,784		0	127,462,521.20		8,664,705.74

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,648,077.70	592,934.37	OTHER LAB	2,215,262.00	39,341.00
MED/SURG SUPPLY	13,186,721.65	628,646.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	70,270,240.50	1,787,900.00	EDUCATION & TRAINING	786.00	0.00
RADIOLOGY-DIAGNOSTIC	12,067,218.00	142,040.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,150,095.00	532,907.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,057,516.12	516,943.06	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,118,392.50	24,606.00	MRI SERVICES	7,175,860.00	63,846.00
IV THERAPY	507,754.00	58,437.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,138,976.00	1,453,289.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,844,599.00	12,783.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,248,452.00	3,434,404.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,202,025.50	153,678.00	AMBULANCE	0.00	0.00
GI SERVICES	1,086,102.00	0.00	CAST ROOM	11,184.00	0.00
EMERGENCY ROOM	18,141,960.00	108,702.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,461,501.00	42,069.00	DRUG-SPECIFIC/HOME IV	0.00	339,326.21
LABORATORY PATHOLOGIC	1,701,724.00	42,900.00	INJECTABLE DRUGS	17,597,566.39	471,388.18
RADIOLOGY THERAPEUTIC	901,848.00	96,456.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,343,033.85	474,970.52	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,900,018.76	24,878.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,347,976.00	1,306,236.00	PATIENT CONVENIENCE	0.00	376.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,050.00	283,879.00	TRAUMA RESPONSE	0.00	212,532.00
PSYCHIATRIC SERVICES	21,865.68	0.00	IMPL DEV CHARGE PATIENTS	6,756,272.57	47,505.52
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,919,787.00	66,386.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,501,694.50	1,337,980.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,476,661.00	173,270.00			
AUDIOLOGY	427,774.00	204.50			
CARDIOLOGY	9,246,383.00	47,960.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,468,729.00	39,562.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,398,852.00	0.00			
			TOTAL ANCILLARY	397,544,958.72	14,558,335.60
			TOTAL ACCOMODATIONS	127,462,521.20	8,664,705.74
			TOTAL CHARGES	525,007,479.92	23,223,041.34

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,086,817.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,068,408.00	CONTRACTUAL ALLOW	687,607.54
NON-COVERD CHARGES	18,409.00	TOTAL MEDICAID LIAB	380,800.46
		LESS: COB	380,800.46
		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	85		0	148,500.00		9,650.00
ROUTINE NURSERY	23		0	52,034.00		6,566.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	108		0	200,534.00		16,216.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	18		0	81,925.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	9		0	65,863.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	27		0	147,788.00		0.00
TOTAL ACCOMODATIONS	135		0	348,322.00		16,216.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,398.68	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,789.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	185,394.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,649.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,820.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,708.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,640.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,879.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	193,251.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,321.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,302.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,764.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,308.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,222.00	0.00	INJECTABLE DRUGS	77,284.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,262.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,164.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	705.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,567.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,228.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,212.00	1,488.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	878.00	0.00			
CARDIOLOGY	18,044.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	720,086.00	2,193.00
			TOTAL ACCOMODATIONS	348,322.00	16,216.00
			TOTAL CHARGES	1,068,408.00	18,409.00

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	153,381,019.49	ADJUSTMENTS	2,046,279.40
COVERED CHARGES	140,920,394.18	CONTRACTUAL ALLOW	117,230,247.30
NON-COVERD CHARGES	12,460,625.31	TOTAL MEDICAID LIAB	23,690,146.88
		LESS: COB	32,771.75
		LESS: COPAYMENT	146,254.81
		REIMBURSEMENT	23,511,120.32
		ALL OTHER	19,179,885.78
		FEE SCHEDULE-LAB	2,461,576.78
		INJECTABLE DRUGS	1,869,657.76
		TOTAL NUMBER OF CLAIMS	74,012

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	904,475.35	5,777.11	OTHER LAB	2,163,304.00	27,789.00
MED/SURG SUPPLY	790,034.34	34,823.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	95.00	EDUCATION & TRAINING	0.00	30,080.00
RADIOLOGY-DIAGNOSTIC	6,391,864.00	521,643.00	OTHER THERAPEUTIC SVC	0.00	635.00
CT SCAN	17,824,847.00	1,020,839.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	524,340.00	83,460.02	FEE SCHEDULE LAB	35,836,666.00	1,172,876.00
EKG/ECG	1,928,844.00	79,838.00	MRI SERVICES	3,506,000.00	562,581.00
IV THERAPY	3,818,951.00	336,078.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,024,797.58	1,225,496.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,522.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	649,736.00	45,365.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,238,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,391,594.36	354,984.64	CAST ROOM	15,481.00	0.00
EMERGENCY ROOM	25,570,181.00	526,666.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	705,540.00	0.00	DRUG-SPECIFIC/HOME IV	1,909.44	203,350.78
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,350,116.77	2,424,541.51
RADIOLOGY THERAPEUTIC	2,036,047.00	559,388.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	180,947.00	58,374.16	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,339.00	11,202.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	663,864.00	PATIENT CONVENIENCE	0.00	583.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,777,107.00	697,801.00	TRAUMA RESPONSE	0.00	100,815.00
PSYCHIATRIC SERVICES	379,908.00	202,017.80	IMPL DEV CHARGE PATIENTS	251,893.34	8,800.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	20.00
OTHER IMAGING SERVICE	1,636,471.00	231,433.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	797,023.00	16,634.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,513,972.00	912,070.00			
AUDIOLOGY	37,288.00	10,017.00			
CARDIOLOGY	2,587,927.00	323,025.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,390.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,932,576.00	7,662.00			
			TOTAL ANCILLARY	140,920,394.18	12,460,625.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	140,920,394.18	12,460,625.31

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
525	9817235000075	05/25/17 - 05/25/17	08/28/17	0.00	20.00	0.00	0.00	0.00
TOTAL				0.00	20.00	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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	653,466.70	ADJUSTMENTS	0.00
COVERED CHARGES	432,413.19	CONTRACTUAL ALLOW	216,215.41
NON-COVERD CHARGES	221,053.51	TOTAL MEDICAID LIAB	216,197.78
		LESS: COB	215,826.49
		LESS: COPAYMENT	371.29
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,304.46	0.00	OTHER LAB	2,813.00	0.00
MED/SURG SUPPLY	449.15	404.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,954.00	3,762.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,357.00	15,941.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	127,669.00	16,429.00
EKG/ECG	4,584.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,081.00	8,700.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,971.00	4,080.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	227.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,817.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,967.00	49,997.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,176.00	3,657.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,357.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	413.84
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,438.58	3,084.67
RADIOLOGY THERAPEUTIC	4,871.00	53,472.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	27.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,478.00	4,172.00	TRAUMA RESPONSE	0.00	13,449.00
PSYCHIATRIC SERVICES	362.00	39,126.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,649.00	1,363.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,718.00	2,976.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,165.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,005.00	0.00			
			TOTAL ANCILLARY	432,413.19	221,053.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	432,413.19	221,053.51

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,338,862.36	ADJUSTMENTS	582.34
COVERED CHARGES	1,307,452.90	CONTRACTUAL ALLOW	1,258,899.92
NON-COVERD CHARGES	31,409.46	TOTAL MEDICAID LIAB	48,552.98
		LESS: COB	2,290.60
		LESS: COPAYMENT	2,290.43
		REIMBURSEMENT	43,971.95
		TOTAL NUMBER OF CLAIMS	827

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,567.18	333.88	OTHER LAB	5,395.00	0.00
MED/SURG SUPPLY	985.00	371.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	100,520.00	4,521.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	181,129.00	7,428.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	256,930.00	7,327.00
EKG/ECG	39,728.00	382.00	MRI SERVICES	27,893.00	0.00
IV THERAPY	2,571.00	450.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,760.00	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	630,260.00	1,821.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,483.72	4,197.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,405.00	448.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,867.00	370.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,242.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,144.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,621.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,110.00	0.00			
			TOTAL ANCILLARY	1,307,452.90	31,409.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,307,452.90	31,409.46

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,819.03	ADJUSTMENTS	0.00
COVERED CHARGES	3,941.40	CONTRACTUAL ALLOW	-216.13
NON-COVERD CHARGES	877.63	TOTAL MEDICAID LIAB	4,157.53
		LESS: COB	4,154.53
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	651.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	179.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,625.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.00	76.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,941.40	877.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,941.40	877.63

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

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

Run Date: 08/29/2018
Run Time: 00:24:59
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,802,033.17	ADJUSTMENTS	935,086.58
COVERED CHARGES	19,089,348.02	CONTRACTUAL ALLOW	15,528,849.34
NON-COVERD CHARGES	712,685.15	TOTAL MEDICAID LIAB	3,560,498.68
		LESS: COB	0.00
		LESS: COPAYMENT	2,091.00
		REIMBURSEMENT	3,558,407.68
		TOTAL NUMBER OF CLAIMS	510

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,028.53	1,484.09	OTHER LAB	0.00	432.00
MED/SURG SUPPLY	263,718.22	1,744.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,546.00	79,681.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,781.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	102,931.00	5,227.00	FEE SCHEDULE LAB	408,910.00	21,310.00
EKG/ECG	3,438.00	764.00	MRI SERVICES	0.00	0.00
IV THERAPY	369,710.00	1,200.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,653,037.72	324,137.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,459.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,523,429.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	905.00	0.00
EMERGENCY ROOM	17,257.00	1,561.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	859,671.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,041.75
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,265,524.29	174,820.25
RADIOLOGY THERAPEUTIC	209,239.00	765.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	5,068.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,552.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,717.00	501.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	553,863.26	1,111.78
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,486.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,686.00	1,488.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,935.00	3,312.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	77,653.00	74,328.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	3,157.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	479,423.00	0.00			
			TOTAL ANCILLARY	19,089,348.02	712,685.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,089,348.02	712,685.15

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

Run Date: 08/29/2018
Run Time: 00:25:09
Page: 16

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,187.50	ADJUSTMENTS	0.00
COVERED CHARGES	19,125.12	CONTRACTUAL ALLOW	6,197.94
NON-COVERD CHARGES	62.38	TOTAL MEDICAID LIAB	12,927.18
		LESS: COB	12,924.18
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	174.00	34.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,206.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	17,720.12	28.38
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	19,125.12	62.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,125.12	62.38

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,448,150.12	ADJUSTMENTS	241,785.02
COVERED CHARGES	2,442,303.34	CONTRACTUAL ALLOW	1,250,502.70
NON-COVERD CHARGES	5,846.78	TOTAL MEDICAID LIAB	1,191,800.64
		LESS: COB	30,919.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,160,881.49

TOTAL NUMBER OF ADMISSIONS 280

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	489		0	224,940.00		900.00
ROUTINE NURSERY	165		0	49,500.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	654		0	274,440.00		900.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	65		0	71,500.00		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	65		0	71,500.00		0.00
TOTAL ACCOMODATIONS	719		0	345,940.00		900.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	186,752.23	0.00	OTHER LAB	7,150.75	0.00
MED/SURG SUPPLY	157,714.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	284,444.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,330.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	115,414.25	521.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,709.57	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,865.00	0.00	MRI SERVICES	16,622.75	0.00
IV THERAPY	379,111.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	89,852.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	293,244.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	74,661.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,070.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	115,997.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	73,459.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,239.00	0.00	INJECTABLE DRUGS	46,149.47	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	361.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	683.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	207.78
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,372.00	339.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,536.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,562.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,739.50	3,696.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,658.25	183.00			
AUDIOLOGY	16,048.50	0.00			
CARDIOLOGY	16,664.25	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	50,949.00	0.00			
			TOTAL ANCILLARY	2,096,363.34	4,946.78
			TOTAL ACCOMODATIONS	345,940.00	900.00
			TOTAL CHARGES	2,442,303.34	5,846.78

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,020.30	ADJUSTMENTS	0.00
COVERED CHARGES	4,020.30	CONTRACTUAL ALLOW	656.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,364.30
		LESS: COB	3,364.30
		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	460.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1		0	460.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1		0	460.00		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	144.71	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	199.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	222.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,802.50	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,010.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	82.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,560.30	0.00
			TOTAL ACCOMODATIONS	460.00	0.00
			TOTAL CHARGES	4,020.30	0.00

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

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

Run Date: 08/29/2018
Run Time: 00:07:14
Page: 5

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,275,616.71	ADJUSTMENTS	63,979.02
COVERED CHARGES	3,080,118.55	CONTRACTUAL ALLOW	2,332,895.73
NON-COVERD CHARGES	195,498.16	TOTAL MEDICAID LIAB	747,222.82
		LESS: COB	1,572.32
		LESS: COPAYMENT	1,527.00
		REIMBURSEMENT	744,123.50
		ALL OTHER	649,011.40
		FEE SCHEDULE-LAB	83,356.26
		INJECTABLE DRUGS	11,755.84
		TOTAL NUMBER OF CLAIMS	2,332

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,506.44	226.59	OTHER LAB	99,325.00	0.00
MED/SURG SUPPLY	91,459.94	886.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	95.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	148,452.50	3,636.00	OTHER THERAPEUTIC SVC	0.00	173.00
CT SCAN	571,825.25	89,360.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,824.25	3,250.43	FEE SCHEDULE LAB	609,288.00	6,817.50
EKG/ECG	48,025.00	3,955.00	MRI SERVICES	49,791.50	9,032.25
IV THERAPY	34,346.25	1,595.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,643.50	5,668.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,384.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,200.25	1,588.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,074.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	999,420.50	17,130.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,132.00	967.50	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,924.57	13,878.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,099.00	4,515.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	621.00	414.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	12.51
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,070.50	4,278.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,525.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,120.25	5,179.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,481.25	2,112.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,935.75	12,311.50			
AUDIOLOGY	205.75	0.00			
CARDIOLOGY	8,389.25	7,637.50			
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	34,047.25	777.25			
			TOTAL ANCILLARY	3,080,118.55	195,498.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,080,118.55	195,498.16

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,968.30	ADJUSTMENTS	0.00
COVERED CHARGES	27,507.80	CONTRACTUAL ALLOW	13,030.97
NON-COVERD CHARGES	3,460.50	TOTAL MEDICAID LIAB	14,476.83
		LESS: COB	14,473.83
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	209.00	0.00	OTHER LAB	563.00	0.00
MED/SURG SUPPLY	26.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	770.00	202.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,965.00	2,698.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,600.75	0.00
EKG/ECG	226.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	676.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,260.50	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	362.80	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	630.25	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	535.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,140.00	0.00			
			TOTAL ANCILLARY	27,507.80	3,460.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,507.80	3,460.50

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	144,449.35	ADJUSTMENTS	435.52
COVERED CHARGES	140,735.26	CONTRACTUAL ALLOW	130,442.30
NON-COVERD CHARGES	3,714.09	TOTAL MEDICAID LIAB	10,292.96
		LESS: COB	0.00
		LESS: COPAYMENT	279.00
		REIMBURSEMENT	10,013.96
		TOTAL NUMBER OF CLAIMS	184

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,633.73	0.00	OTHER LAB	563.00	0.00
MED/SURG SUPPLY	53.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,902.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,601.25	1,748.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,508.25	265.00
EKG/ECG	1,243.00	113.00	MRI SERVICES	2,049.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	154.50	34.75	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	79,744.50	142.50	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	1,559.78	292.59
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	1,722.00	1,035.50			
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	140,735.26	3,714.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	140,735.26	3,714.09

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,981.95	ADJUSTMENTS	0.00
COVERED CHARGES	2,694.95	CONTRACTUAL ALLOW	1,410.41
NON-COVERD CHARGES	287.00	TOTAL MEDICAID LIAB	1,284.54
		LESS: COB	1,281.54
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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

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

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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	173.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	563.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,914.50	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	43.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE 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	2,694.95	287.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,694.95	287.00

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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:56:02
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	303,891,646.92	ADJUSTMENTS	29,435,808.31
COVERED CHARGES	296,428,979.12	CONTRACTUAL ALLOW	206,108,882.96
NON-COVERD CHARGES	7,462,667.80	TOTAL MEDICAID LIAB	90,320,096.16
		LESS: COB	418,185.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	89,901,911.10

TOTAL NUMBER OF ADMISSIONS 2,833

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14,519		41	22,185,695.00		4,554,014.00
ROUTINE NURSERY	922		0	2,872,824.50		8,187.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15,441		41	25,058,519.50		4,562,201.50
SPECIAL CARE SERVICES						
CCU	1,420		0	6,439,994.50		28,775.50
ICU	3		0	1,889.00		0.00
NICU	2,565		0	15,610,729.50		0.00
PED ICU	4,509		0	20,706,927.50		58,999.50
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	8,497		0	42,759,540.50		87,775.00
TOTAL ACCOMODATIONS	23,938		41	67,818,060.00		4,649,976.50

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,505,836.82	91,143.50	OTHER LAB	1,047,750.00	2,687.50
MED/SURG SUPPLY	14,502,301.91	121,637.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	39,031,604.23	716,459.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,090,533.00	5,514.50	OTHER THERAPEUTIC SVC	45,422.50	168,704.00
CT SCAN	1,615,806.00	24,761.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,470,908.00	6,653.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	307,915.50	976.50	MRI SERVICES	1,613,975.50	0.00
IV THERAPY	82,332.00	0.00	PROFESSIONAL FEES	0.00	5,290.50
OPERATING ROOM	29,265,147.00	26,346.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,634,822.29	214,059.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,556,534.50	12,461.00	AMBULANCE	0.00	0.00
GI SERVICES	23,937.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,786,990.50	13,484.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	990,133.00	1,839.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,768,099.50	64.00	INJECTABLE DRUGS	8,155.00	0.00
RADIOLOGY THERAPEUTIC	210,694.50	825.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	861,034.00	6,344.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	625,697.00	2,083.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	33,287.50	126,563.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	738.50	51,967.00	TRAUMA RESPONSE	0.00	84,544.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,468,531.37	1,968.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	656,199.00	78,602.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,480,307.00	732,986.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	138,204.50	11,432.00			
AUDIOLOGY	51,895.50	0.00			
CARDIOLOGY	5,940,322.50	7,194.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,323,154.50	5,774.00			
ORGAN ACQUISITION	4,219,523.50	57,764.50			
TREATMENT/OBSERV. RM	253,125.00	232,560.00			
			TOTAL ANCILLARY	228,610,919.12	2,812,691.30
			TOTAL ACCOMODATIONS	67,818,060.00	4,649,976.50
			TOTAL CHARGES	296,428,979.12	7,462,667.80

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

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

Run Date: 08/29/2018
 Run Time: 00:56:14
 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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,773,084.84	ADJUSTMENTS	0.00
COVERED CHARGES	4,734,081.34	CONTRACTUAL ALLOW	1,395,150.52
NON-COVERD CHARGES	39,003.50	TOTAL MEDICAID LIAB	3,338,930.82
		LESS: COB	3,338,930.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 48

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	176		0	271,255.50		24,577.00
ROUTINE NURSERY	4		0	6,298.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	180		0	277,553.50		24,577.00
SPECIAL CARE SERVICES						
CCU	63		0	289,463.50		0.00
ICU	0		0	0.00		0.00
NICU	26		0	158,067.00		0.00
PED ICU	14		0	63,763.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	103		0	511,293.50		0.00
TOTAL ACCOMODATIONS	283		0	788,847.00		24,577.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	471,620.50	0.00	OTHER LAB	35,471.00	0.00
MED/SURG SUPPLY	333,321.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	392,311.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	83,494.50	0.00	OTHER THERAPEUTIC SVC	0.00	1,589.00
CT SCAN	20,924.50	6,315.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,431.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,431.50	0.00	MRI SERVICES	12,298.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	5,566.00
OPERATING ROOM	760,988.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	229,875.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	319,129.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,980.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,877.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	49,225.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	32,311.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,708.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,343.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,663.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	956.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	769,917.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,390.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,883.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,077.50	0.00			
AUDIOLOGY	850.00	0.00			
CARDIOLOGY	147,532.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	129,298.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,880.00	0.00			
			TOTAL ANCILLARY	3,945,234.34	14,426.50
			TOTAL ACCOMODATIONS	788,847.00	24,577.00
			TOTAL CHARGES	4,734,081.34	39,003.50

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,246,777.75	ADJUSTMENTS	3,904,710.39
COVERED CHARGES	71,624,995.62	CONTRACTUAL ALLOW	54,866,177.53
NON-COVERD CHARGES	7,621,782.13	TOTAL MEDICAID LIAB	16,758,818.09
		LESS: COB	17,714.73
		LESS: COPAYMENT	249.00
		REIMBURSEMENT	16,740,854.36
		ALL OTHER	12,815,273.89
		FEE SCHEDULE-LAB	896,240.04
		INJECTABLE DRUGS	3,029,340.43

TOTAL NUMBER OF CLAIMS 19,515

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,495,494.75	8,534.00	OTHER LAB	631,256.00	7,359.00
MED/SURG SUPPLY	3,538,252.81	5,726.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,545,792.50	54,469.50	OTHER THERAPEUTIC SVC	545.50	6,901.00
CT SCAN	1,644,664.00	51,481.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,436.00	19,469.00	FEE SCHEDULE LAB	15,590,757.62	2,598,268.29
EKG/ECG	127,032.00	19,456.50	MRI SERVICES	3,648,294.50	297,125.50
IV THERAPY	1,361,496.00	33,963.00	PROFESSIONAL FEES	0.00	2,878.50
OPERATING ROOM	9,687,624.20	638,065.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	769,297.50	90,657.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,243,912.00	1,114.00	AMBULANCE	0.00	0.00
GI SERVICES	90,842.00	8,033.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,948,870.00	52,065.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,620,172.00	426.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,110,965.25	1,709,647.50
RADIOLOGY THERAPEUTIC	432,099.50	13,332.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,140.50	6,719.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	394,536.00	38,456.50	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	1,243,715.99	250,011.00	TRAUMA RESPONSE	0.00	99,137.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	624,461.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	924,971.00	116,644.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,193,136.00	4,104.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	487,534.00	98,978.50			
AUDIOLOGY	169,151.50	6,254.50			
CARDIOLOGY	1,710,081.50	698,933.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,961,217.50	2,584.50			
ORGAN ACQUISITION	0.00	56,912.01			
TREATMENT/OBSERV. RM	1,405,246.50	624,074.01			
			TOTAL ANCILLARY	71,624,995.62	7,621,782.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	71,624,995.62	7,621,782.13

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 AT
1405 CLIFTON RD NE
ATLANTA,GA 30322-1062

PROVIDER NUMBER
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,819,277.23	ADJUSTMENTS	0.00
COVERED CHARGES	1,383,725.48	CONTRACTUAL ALLOW	290,905.18
NON-COVERD CHARGES	435,551.75	TOTAL MEDICAID LIAB	1,092,820.30
		LESS: COB	1,092,778.30
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 319

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,245.00	0.00	OTHER LAB	19,832.50	2,349.00
MED/SURG SUPPLY	136,819.50	344.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,656.00	526.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,879.50	3,151.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	512.50	0.00	FEE SCHEDULE LAB	208,575.23	36,101.50
EKG/ECG	1,302.00	1,841.00	MRI SERVICES	70,078.00	14,743.00
IV THERAPY	4,419.00	0.00	PROFESSIONAL FEES	0.00	2,511.50
OPERATING ROOM	212,984.50	133,161.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,747.50	189.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	216,923.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,680.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,142.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,668.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	132,051.25	78,838.25
RADIOLOGY THERAPEUTIC	45,441.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,696.50	487.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,838.50	7,243.50	TRAUMA RESPONSE	0.00	1,196.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,064.50	9,627.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,767.00	25,467.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,728.00	1,239.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,031.50	1,345.50			
AUDIOLOGY	687.00	0.00			
CARDIOLOGY	34,283.00	115,045.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	33,452.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,219.00	144.00			
			TOTAL ANCILLARY	1,383,725.48	435,551.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,383,725.48	435,551.75

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,429,655.75	ADJUSTMENTS	548.40
COVERED CHARGES	1,308,717.25	CONTRACTUAL ALLOW	1,247,082.37
NON-COVERD CHARGES	120,938.50	TOTAL MEDICAID LIAB	61,634.88
		LESS: COB	29.45
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	61,593.43
		TOTAL NUMBER OF CLAIMS	1,102

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,234.00	0.00	OTHER LAB	9,402.50	0.00
MED/SURG SUPPLY	6,710.25	146.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,337.50	1,160.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,597.00	17,258.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	247,248.00	46,712.50
EKG/ECG	6,510.00	325.50	MRI SERVICES	4,938.50	17,398.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,188.00
OPERATING ROOM	3,373.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,066.00	350.00	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	837,979.00	2,651.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,055.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,468.50	21,950.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,898.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,643.50	5,152.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,398.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,190.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,952.00	4,248.00			
			TOTAL ANCILLARY	1,308,717.25	120,938.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,308,717.25	120,938.50

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: 08/29/2018
Run Time: 00:57:12
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,623.25	ADJUSTMENTS	0.00
COVERED CHARGES	4,556.75	CONTRACTUAL ALLOW	2,277.41
NON-COVERD CHARGES	66.50	TOTAL MEDICAID LIAB	2,279.34
		LESS: COB	2,279.34
		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: 08/29/2018
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49.00	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	702.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	339.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,343.50	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	122.25	66.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,556.75	66.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,556.75	66.50

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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,604,165.62	ADJUSTMENTS	662,773.14
COVERED CHARGES	18,122,278.72	CONTRACTUAL ALLOW	14,866,062.93
NON-COVERD CHARGES	3,481,886.90	TOTAL MEDICAID LIAB	3,256,215.79
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,256,215.79

TOTAL NUMBER OF CLAIMS 363

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,132.75	0.00	OTHER LAB	1,174.50	0.00
MED/SURG SUPPLY	2,971,372.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	287,650.00	211,093.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,369.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	8,688.00	FEE SCHEDULE LAB	787,083.00	390,063.00
EKG/ECG	2,380.00	11,392.50	MRI SERVICES	30,694.00	4,765.00
IV THERAPY	125,280.00	1,100.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,587,641.10	668,618.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,069.00	6,149.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,796,682.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,123.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,815.00	1,529.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	207,666.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,881,991.00	646,949.00
RADIOLOGY THERAPEUTIC	47,408.50	4,652.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,545.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,355.50	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	9,892.00	6,323.50	TRAUMA RESPONSE	0.00	4,759.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,910,466.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,464.50	6,840.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	36,771.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,453.50	0.00			
CARDIOLOGY	2,942,669.50	1,456,039.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,901.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	239,128.00	48,024.00			
			TOTAL ANCILLARY	18,122,278.72	3,481,886.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,122,278.72	3,481,886.90

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	221,985.00	ADJUSTMENTS	0.00
COVERED CHARGES	193,951.25	CONTRACTUAL ALLOW	53,649.57
NON-COVERD CHARGES	28,033.75	TOTAL MEDICAID LIAB	140,301.68
		LESS: COB	140,301.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,036.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35,816.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,226.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,929.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,213.50	4,848.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,411.00	1,123.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,091.50	2,602.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,774.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	784.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,625.00	832.25
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	10,556.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,673.00	16,698.50			
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	3,744.00	0.00			
			TOTAL ANCILLARY	193,951.25	28,033.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	193,951.25	28,033.75

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	323,087.22	ADJUSTMENTS	0.00
COVERED CHARGES	322,766.26	CONTRACTUAL ALLOW	187,543.37
NON-COVERD CHARGES	320.96	TOTAL MEDICAID LIAB	135,222.89
		LESS: COB	6,407.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	128,815.84

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	26		0	31,772.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	26		0	31,772.00		0.00
SPECIAL CARE SERVICES						
CCU	19		0	34,912.50		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	19		0	34,912.50		0.00
TOTAL ACCOMODATIONS	45		0	66,684.50		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,407.41	0.00	OTHER LAB	1,118.00	0.00
MED/SURG SUPPLY	14,510.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	57,142.85	0.00	EDUCATION & TRAINING	605.00	0.00
RADIOLOGY-DIAGNOSTIC	10,200.00	320.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,160.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,035.23	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,361.00	0.00	MRI SERVICES	4,137.00	0.00
IV THERAPY	11,711.75	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	43,429.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,970.47	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,129.95	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	1,033.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	616.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,411.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,033.96	0.00			
			TOTAL ANCILLARY	256,081.76	320.96
			TOTAL ACCOMODATIONS	66,684.50	0.00
			TOTAL CHARGES	322,766.26	320.96

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,822,669.53	ADJUSTMENTS	110,691.07
COVERED CHARGES	4,712,719.47	CONTRACTUAL ALLOW	3,784,523.60
NON-COVERD CHARGES	109,950.06	TOTAL MEDICAID LIAB	928,195.87
		LESS: COB	2,324.81
		LESS: COPAYMENT	2,808.00
		REIMBURSEMENT	923,063.06
		ALL OTHER	858,699.55
		FEE SCHEDULE-LAB	54,441.71
		INJECTABLE DRUGS	9,921.80

TOTAL NUMBER OF CLAIMS 1,883

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,666.99	618.63	OTHER LAB	36,208.00	0.00
MED/SURG SUPPLY	37,601.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	960.00
RADIOLOGY-DIAGNOSTIC	244,512.66	10,216.12	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	816,016.00	28,013.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	180,730.00	6,445.00	FEE SCHEDULE LAB	612,334.33	7,737.94
EKG/ECG	50,768.00	2,578.00	MRI SERVICES	222,780.00	6,472.00
IV THERAPY	340,174.25	9,537.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	253,764.00	11,195.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,808.72	1,730.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	63,137.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	73,425.00	2,639.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,136,403.09	4,118.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,335.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71,554.65	5,204.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,520.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,195.89	576.24
LITHOTRIPSY	70,125.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,217.00	8,362.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,824.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,382.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	42,979.61	1,026.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,776.24	0.00			
			TOTAL ANCILLARY	4,712,719.47	109,950.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,712,719.47	109,950.06

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,691.30	ADJUSTMENTS	0.00
COVERED CHARGES	30,562.93	CONTRACTUAL ALLOW	8,688.69
NON-COVERD CHARGES	9,128.37	TOTAL MEDICAID LIAB	21,874.24
		LESS: COB	21,856.24
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	309.92	501.37	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	179.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,643.00	830.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,350.00	6,373.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	945.00	0.00	FEE SCHEDULE LAB	7,426.17	1,049.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,680.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,033.09	375.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	510.75	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.	2,886.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,562.93	9,128.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,562.93	9,128.37

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	242,631.00	ADJUSTMENTS	141.00
COVERED CHARGES	230,867.33	CONTRACTUAL ALLOW	223,367.33
NON-COVERD CHARGES	11,763.67	TOTAL MEDICAID LIAB	7,500.00
		LESS: COB	31.56
		LESS: COPAYMENT	288.00
		REIMBURSEMENT	7,180.44
		TOTAL NUMBER OF CLAIMS	150

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,426.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	518.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,371.00	641.92	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,238.00	9,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,107.00	437.00
EKG/ECG	2,948.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,346.00	850.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	115,549.58	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,162.16	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	0.00	713.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	230,867.33	11,763.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	230,867.33	11,763.67

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,456.35	ADJUSTMENTS	0.00
COVERED CHARGES	6,722.35	CONTRACTUAL ALLOW	4,903.05
NON-COVERD CHARGES	4,734.00	TOTAL MEDICAID LIAB	1,819.30
		LESS: COB	1,816.30
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96.00	75.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	4,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,060.00	109.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,260.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,610.35	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	396.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,722.35	4,734.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,722.35	4,734.00

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	158,361.66	ADJUSTMENTS	9,725.78
COVERED CHARGES	155,524.07	CONTRACTUAL ALLOW	131,209.62
NON-COVERD CHARGES	2,837.59	TOTAL MEDICAID LIAB	24,314.45
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,314.45

TOTAL NUMBER OF CLAIMS 5

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

HIGGINS GENERAL HOSPITAL
 200 ALLEN MEMORIAL DR
 BREMEN,GA 30110-2012

PROVIDER NUMBER
 000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,520.09	0.00	OTHER LAB	3,512.00	0.00
MED/SURG SUPPLY	2,058.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	90.00
RADIOLOGY-DIAGNOSTIC	1,896.00	320.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,761.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,557.00	0.00
EKG/ECG	1,799.00	0.00	MRI SERVICES	3,236.00	0.00
IV THERAPY	16,171.00	1,891.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,761.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,310.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,576.40	245.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	355.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	286.87	80.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	210.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	480.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,481.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,157.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,605.06	0.00			
			TOTAL ANCILLARY	155,524.07	2,837.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	155,524.07	2,837.59

Report : 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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
 1601 WATSON BLVD
 WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER 000000976A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,091,292.61	ADJUSTMENTS	606,139.01
COVERED CHARGES	19,672,194.22	CONTRACTUAL ALLOW	11,802,805.36
NON-COVERD CHARGES	1,419,098.39	TOTAL MEDICAID LIAB	7,869,388.86
		LESS: COB	60,153.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,809,235.81

TOTAL NUMBER OF ADMISSIONS 1,156

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,341		5	4,227,755.00		1,330,325.00
ROUTINE NURSERY	402		0	356,925.00		26,925.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,743		5	4,584,680.00		1,357,250.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	661		0	1,243,944.00		0.00
NICU	15		0	52,500.00		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	676		0	1,296,444.00		0.00
TOTAL ACCOMODATIONS	5,419		5	5,881,124.00		1,357,250.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,492,503.37	3,640.45	OTHER LAB	75,099.24	0.00
MED/SURG SUPPLY	317,338.72	1,219.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,581,089.16	1,843.29	EDUCATION & TRAINING	420.00	0.00
RADIOLOGY-DIAGNOSTIC	357,487.39	670.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	489,000.00	3,816.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	280,141.50	188.28	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	367,136.00	1,788.00	MRI SERVICES	118,000.00	0.00
IV THERAPY	18,930.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,799,744.08	5,328.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	700,830.00	11,919.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,284,927.00	8,469.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	241,200.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,538,244.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	135,174.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	38,196.64	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	328.86	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,480.17	1,251.30	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	187,836.00	5,823.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,855.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	373,065.15	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,000.00
OTHER IMAGING SERVICE	87,635.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	96,014.94	3,710.62			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	60,378.32	2,530.98			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	843,227.60	650.57			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	96,967.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	147,819.33	0.00			
			TOTAL ANCILLARY	13,791,070.22	61,848.39
			TOTAL ACCOMODATIONS	5,881,124.00	1,357,250.00
			TOTAL CHARGES	19,672,194.22	1,419,098.39

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: 08/29/2018
Run Time: 00:13:49
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017341064702	11/07/17 - 11/14/17	12/11/17	0.00	1,000.00	0.00	0.00	0.00
615	2017355075845	12/11/17 - 12/16/17	12/25/17	0.00	1,000.00	0.00	0.00	0.00
615	2018005056134	12/26/17 - 12/29/17	01/08/18	0.00	1,000.00	0.00	0.00	0.00
615	2018011068782	12/27/17 - 01/06/18	01/15/18	0.00	1,000.00	0.00	0.00	0.00
615	2018017002233	07/16/17 - 07/21/17	01/22/18	0.00	1,000.00	0.00	0.00	0.00
615	2218047015463	01/17/17 - 01/20/17	02/19/18	0.00	1,000.00	0.00	0.00	0.00
615	5918052001470	11/29/17 - 12/02/17	02/26/18	0.00	1,000.00	0.00	0.00	0.00
616	2018089048882	01/13/17 - 01/27/17	04/02/18	0.00	1,000.00	0.00	0.00	0.00
616	2218218008584	12/01/17 - 12/08/17	08/13/18	0.00	1,000.00	0.00	0.00	0.00
TOTAL				0.00	9,000.00	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: 08/29/2018
 Run Time: 00:14:02
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	149,935.13	ADJUSTMENTS	0.00
COVERED CHARGES	132,575.13	CONTRACTUAL ALLOW	46,474.52
NON-COVERD CHARGES	17,360.00	TOTAL MEDICAID LIAB	86,100.61
		LESS: COB	86,100.61
		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	44		0	42,900.00		17,360.00
ROUTINE NURSERY	0		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	42,900.00		17,360.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	42,900.00		17,360.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,118.16	0.00	OTHER LAB	315.72	0.00
MED/SURG SUPPLY	1,026.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,927.59	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	335.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,500.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	445.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	596.00	0.00	MRI SERVICES	2,000.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,593.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,564.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	184.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,350.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,371.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,044.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,303.00	0.00			
			TOTAL ANCILLARY	89,675.13	0.00
			TOTAL ACCOMODATIONS	42,900.00	17,360.00
			TOTAL CHARGES	132,575.13	17,360.00

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: 08/29/2018
Run Time: 00:14:03
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,354,705.04	ADJUSTMENTS	454,728.20
COVERED CHARGES	14,173,856.62	CONTRACTUAL ALLOW	10,983,915.54
NON-COVERD CHARGES	1,180,848.42	TOTAL MEDICAID LIAB	3,189,941.08
		LESS: COB	21,618.00
		LESS: COPAYMENT	8,104.35
		REIMBURSEMENT	3,160,218.73
		ALL OTHER	2,691,795.99
		FEE SCHEDULE-LAB	345,032.50
		INJECTABLE DRUGS	123,390.24

TOTAL NUMBER OF CLAIMS 6,555

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,962.75	11,549.39	OTHER LAB	246,466.04	0.00
MED/SURG SUPPLY	172,277.91	9,203.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	3,695.00	166.00
RADIOLOGY-DIAGNOSTIC	530,819.47	28,217.77	OTHER THERAPEUTIC SVC	0.00	1,065.90
CT SCAN	627,382.00	61,250.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,229.18	42,932.67	FEE SCHEDULE LAB	1,230,289.80	82,781.10
EKG/ECG	407,388.00	596.00	MRI SERVICES	90,000.00	20,000.00
IV THERAPY	684,498.90	52,654.50	PROFESSIONAL FEES	0.00	59.40
OPERATING ROOM	1,587,754.00	320,167.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,508.50	0.00	REHAB THERAPY	0.00	832.00
RESPIRATORY SERVICES	89,458.50	29,358.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	209,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,077,808.96	20,047.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	316,506.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	432,831.20	111,108.16
RADIOLOGY THERAPEUTIC	7,945.20	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	50,677.71	18,601.11	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,503.90	4,000.61	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	110,637.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,126.79	7,024.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,382.01	6,533.53
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	259,143.77	43,978.49			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,203.91	10,435.08			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,253.62	16,791.46			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	327,222.05	169,540.11			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,441.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	405,380.45	1,317.50			
			TOTAL ANCILLARY	14,173,856.62	1,180,848.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,173,856.62	1,180,848.42

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	393,875.16	ADJUSTMENTS	0.00
COVERED CHARGES	250,708.61	CONTRACTUAL ALLOW	124,437.74
NON-COVERD CHARGES	143,166.55	TOTAL MEDICAID LIAB	126,270.87
		LESS: COB	126,018.32
		LESS: COPAYMENT	252.55
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 165

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,216.79	74.96	OTHER LAB	1,896.72	0.00
MED/SURG SUPPLY	10,357.15	309.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,746.73	1,302.04	OTHER THERAPEUTIC SVC	0.00	796.80
CT SCAN	6,500.00	7,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	357.24	429.56	FEE SCHEDULE LAB	25,937.11	2,131.50
EKG/ECG	5,066.00	0.00	MRI SERVICES	1,000.00	1,000.00
IV THERAPY	6,199.50	0.00	PROFESSIONAL FEES	0.00	59.40
OPERATING ROOM	2,062.78	83,628.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	856.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,950.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	127,287.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,402.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,757.43	3,476.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,617.93	2,920.56	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,750.00	589.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,861.41	133.66
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,331.37	11,104.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,403.52	4,033.22			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	810.00	19,766.78			
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	8,108.43	3,910.00			
			TOTAL ANCILLARY	250,708.61	143,166.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	250,708.61	143,166.55

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

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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	415,055.16	ADJUSTMENTS	329.64
COVERED CHARGES	405,525.15	CONTRACTUAL ALLOW	390,812.93
NON-COVERD CHARGES	9,530.01	TOTAL MEDICAID LIAB	14,712.22
		LESS: COB	0.00
		LESS: COPAYMENT	327.22
		REIMBURSEMENT	14,385.00
		TOTAL NUMBER OF CLAIMS	263

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1601 WATSON BLVD	000000976A	SERVICE DATES	01/01/17	THROUGH	12/31/17
WARNER ROBINS,GA 31093-3431		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	501.03	0.00	OTHER LAB	1,578.60	0.00
MED/SURG SUPPLY	690.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,492.76	1,450.11	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,250.00	1,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	847.26	1,522.95	FEE SCHEDULE LAB	31,336.73	2,529.06
EKG/ECG	4,172.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,338.00	184.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,933.99	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	355.50	129.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	321,806.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	348.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,046.48	635.79
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	7,893.00	1,578.60			
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	935.00	0.00			
			TOTAL ANCILLARY	405,525.15	9,530.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	405,525.15	9,530.01

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

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

Run Date: 08/29/2018
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Page: 12

HOUSTON MEDICAL CENTER
1601 WATSON BLVD
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,667.14	ADJUSTMENTS	0.00
COVERED CHARGES	13,586.83	CONTRACTUAL ALLOW	9,279.48
NON-COVERD CHARGES	80.31	TOTAL MEDICAID LIAB	4,307.35
		LESS: COB	4,301.35
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	167.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	750.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,724.90	36.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	162.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,100.00	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	31.67	44.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	631.44	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,586.83	80.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,586.83	80.31

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,316,072.31	ADJUSTMENTS	27,707.70
COVERED CHARGES	1,105,321.61	CONTRACTUAL ALLOW	889,057.64
NON-COVERD CHARGES	210,750.70	TOTAL MEDICAID LIAB	216,263.97
		LESS: COB	0.00
		LESS: COPAYMENT	166.08
		REIMBURSEMENT	216,097.89

TOTAL NUMBER OF CLAIMS 39

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,518.39	867.66	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	90,499.62	6,506.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,349.14	6,610.74	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	750.00	1,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,762.87	FEE SCHEDULE LAB	17,137.69	2,548.12
EKG/ECG	9,834.00	894.00	MRI SERVICES	1,000.00	0.00
IV THERAPY	9,088.50	1,845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	460,162.25	81,460.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,434.00	820.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,597.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,558.00	900.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	83,606.37	12,279.66
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	53,454.57	82,322.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	315.72	315.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,403.52	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	180,734.34	9,116.95			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,378.50	0.00			
			TOTAL ANCILLARY	1,105,321.61	210,750.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,105,321.61	210,750.70

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,395.96	ADJUSTMENTS	0.00
COVERED CHARGES	12,386.96	CONTRACTUAL ALLOW	3,586.71
NON-COVERD CHARGES	9.00	TOTAL MEDICAID LIAB	8,800.25
		LESS: COB	8,800.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	9.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,080.60	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	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	11,294.36	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,386.96	9.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,386.96	9.00

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,054,154.60	ADJUSTMENTS	127,399.15
COVERED CHARGES	1,006,589.15	CONTRACTUAL ALLOW	532,075.55
NON-COVERD CHARGES	47,565.45	TOTAL MEDICAID LIAB	474,513.60
		LESS: COB	5,420.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	469,093.23

TOTAL NUMBER OF ADMISSIONS 118

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	190		0	96,525.00		31,475.00
ROUTINE NURSERY	84		0	42,675.00		7,000.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	274		0	139,200.00		38,475.00
SPECIAL CARE SERVICES						
CCU	2		0	1,050.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	1,050.00		0.00
TOTAL ACCOMODATIONS	276		0	140,250.00		38,475.00

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,922.47	342.90	OTHER LAB	1,298.40	0.00
MED/SURG SUPPLY	89,040.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	76,661.76	56.26	EDUCATION & TRAINING	1,664.40	0.00
RADIOLOGY-DIAGNOSTIC	7,862.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,910.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,080.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	286,294.80	486.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	161,744.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,761.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,370.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,046.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	10,697.65	0.00	INJECTABLE DRUGS	38,742.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,462.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	162.73
OTHER IMAGING SERVICE	5,320.80	0.00			
BLOOD	0.00	3,240.16			
BLOOD STORAGE & PRO.	0.00	1,728.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	3,074.40			
CARDIOLOGY	2,648.40	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	810.00	0.00			
			TOTAL ANCILLARY	866,339.15	9,090.45
			TOTAL ACCOMODATIONS	140,250.00	38,475.00
			TOTAL CHARGES	1,006,589.15	47,565.45

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

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

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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	5218072026326	07/13/17 - 07/16/17	04/02/18	0.00	162.73	0.00	0.00	0.00
TOTAL				0.00	162.73	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: 08/29/2018
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/16 THROUGH 11/30/17
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: 08/29/2018
Run Time: 00:38:18
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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,918,653.74	ADJUSTMENTS	79,548.82
COVERED CHARGES	1,791,358.61	CONTRACTUAL ALLOW	1,377,744.68
NON-COVERD CHARGES	127,295.13	TOTAL MEDICAID LIAB	413,613.93
		LESS: COB	1,598.23
		LESS: COPAYMENT	549.00
		REIMBURSEMENT	411,466.70
		ALL OTHER	364,124.21
		FEE SCHEDULE-LAB	45,807.52
		INJECTABLE DRUGS	1,534.97

TOTAL NUMBER OF CLAIMS 793

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,580.98	54.50	OTHER LAB	3,350.40	0.00
MED/SURG SUPPLY	39,004.55	95.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	210.41	EDUCATION & TRAINING	0.00	1,664.40
RADIOLOGY-DIAGNOSTIC	72,950.40	3,212.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	120,768.00	17,902.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	296,914.87	2,523.94
EKG/ECG	18,822.00	720.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,235.00	8,760.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	624,164.00	60,556.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,795.35	4,864.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	54,823.20	8,620.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	203,538.49	1,459.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,772.40	668.40	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,084.17	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	150.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	810.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	626.40
OTHER IMAGING SERVICE	41,912.40	9,384.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,296.80	2,648.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,282.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68,063.60	2,363.40			
			TOTAL ANCILLARY	1,791,358.61	127,295.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,791,358.61	127,295.13

Report : CLM-0804-0
Process : CLMJ0800
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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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
461	2217174018064	06/08/17 - 06/08/17	06/26/17	0.00	324.00	0.00	0.00	0.00
7363	2217338000961	11/17/17 - 11/17/17	12/11/17	0.00	302.40	0.00	0.00	0.00
TOTAL				0.00	626.40	0.00	0.00	0.00

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

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

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

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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,139.03	ADJUSTMENTS	0.00
COVERED CHARGES	1,139.03	CONTRACTUAL ALLOW	735.84
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	403.19
		LESS: COB	403.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 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	132.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	129.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	811.20	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	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	1,139.03	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,139.03	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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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	123,071.63	ADJUSTMENTS	544.40
COVERED CHARGES	122,569.15	CONTRACTUAL ALLOW	116,471.69
NON-COVERD CHARGES	502.48	TOTAL MEDICAID LIAB	6,097.46
		LESS: COB	0.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	5,875.46
		TOTAL NUMBER OF CLAIMS	109

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,180.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	816.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,176.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,123.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,659.02	12.88
EKG/ECG	1,440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,091.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,868.80	424.80	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	63,959.40	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	338.42	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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	64.80
OTHER IMAGING SERVICE	702.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,213.28	0.00			
			TOTAL ANCILLARY	122,569.15	502.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	122,569.15	502.48

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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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217038008640	01/30/17 - 01/30/17	02/13/17	0.00	64.80	0.00	0.00	0.00
TOTAL				0.00	64.80	0.00	0.00	0.00

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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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	470.40	ADJUSTMENTS	0.00
COVERED CHARGES	470.40	CONTRACTUAL ALLOW	406.21
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	64.19
		LESS: COB	64.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

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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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 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	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	405.60	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	470.40	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	470.40	0.00

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

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA,GA 31774-5011

PROVIDER NUMBER
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,371.51	ADJUSTMENTS	5,748.49
COVERED CHARGES	116,157.91	CONTRACTUAL ALLOW	87,385.46
NON-COVERD CHARGES	4,213.60	TOTAL MEDICAID LIAB	28,772.45
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	28,757.45
		TOTAL NUMBER OF CLAIMS	5

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,191.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,678.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	87.60
RADIOLOGY-DIAGNOSTIC	302.40	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	3,932.61	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,314.00	2.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	736.80	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,673.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	229.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,000.80	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	835.20	50.00			
			TOTAL ANCILLARY	116,157.91	4,213.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	116,157.91	4,213.60

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	12/01/16	THROUGH	11/30/17
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

JASPER MEMORIAL HOSP
 898 COLLEGE ST
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER 000000998A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,049.31	ADJUSTMENTS	0.00
COVERED CHARGES	4,049.31	CONTRACTUAL ALLOW	672.19
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,377.12
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,377.12

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	365.75	0.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	365.75	0.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	365.75	0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
 898 COLLEGE ST
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,018.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	594.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,395.36	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209.58	0.00	OTHER THERAPEUTIC SVC	0.00	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	186.46	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	279.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,683.56	0.00
			TOTAL ACCOMODATIONS	365.75	0.00
			TOTAL CHARGES	4,049.31	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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	340,628.03	ADJUSTMENTS	29,192.25
COVERED CHARGES	325,809.50	CONTRACTUAL ALLOW	149,774.94
NON-COVERD CHARGES	14,818.53	TOTAL MEDICAID LIAB	176,034.56
		LESS: COB	0.00
		LESS: COPAYMENT	813.00
		REIMBURSEMENT	175,221.56
		ALL OTHER	158,215.65
		FEE SCHEDULE-LAB	13,797.98
		INJECTABLE DRUGS	3,207.93

TOTAL NUMBER OF CLAIMS 619

JASPER MEMORIAL HOSP
 898 COLLEGE ST
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,470.64	0.00	OTHER LAB	1,214.31	0.00
MED/SURG SUPPLY	6,456.93	183.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,301.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,160.01	5,890.59	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,174.95	1,024.43	FEE SCHEDULE LAB	107,441.80	4,640.83
EKG/ECG	4,902.11	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,125.64	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,198.06	85.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,378.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,210.05	1,985.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,514.72	530.44	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	6,517.44	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	489.07	478.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,461.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,792.20	0.00			
			TOTAL ANCILLARY	325,809.50	14,818.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	325,809.50	14,818.53

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

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,569.05	ADJUSTMENTS	0.00
COVERED CHARGES	1,389.14	CONTRACTUAL ALLOW	-263.90
NON-COVERD CHARGES	2,179.91	TOTAL MEDICAID LIAB	1,653.04
		LESS: COB	1,653.04
		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: 08/29/2018
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
 898 COLLEGE ST
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	64.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,166.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	385.34	13.01
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	304.17	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	543.52	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	60.11	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	1,389.14	2,179.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,389.14	2,179.91

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,271.12	ADJUSTMENTS	0.00
COVERED CHARGES	7,259.68	CONTRACTUAL ALLOW	5,659.68
NON-COVERD CHARGES	11.44	TOTAL MEDICAID LIAB	1,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	1,567.00
		TOTAL NUMBER OF CLAIMS	32

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	393.86	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,587.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	258.34	11.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,259.68	11.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,259.68	11.44

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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO,GA 31064-1258

PROVIDER NUMBER
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
 163 S TALLAHASSEE ST
 HAZLEHURST,GA 31539-6465

PROVIDER NUMBER 000001009A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	735,693.32	ADJUSTMENTS	0.00
COVERED CHARGES	731,143.32	CONTRACTUAL ALLOW	487,115.36
NON-COVERD CHARGES	4,550.00	TOTAL MEDICAID LIAB	244,027.96
		LESS: COB	3,422.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	240,605.82

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	129		0	58,050.00		4,550.00
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	129		0	58,050.00		4,550.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	21		0	21,000.00		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	21		0	21,000.00		0.00
TOTAL ACCOMODATIONS	150		0	79,050.00		4,550.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL
 163 S TALLAHASSEE ST
 HAZLEHURST,GA 31539-6465

PROVIDER NUMBER
 000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	258,735.00	0.00	OTHER LAB	1,682.90	0.00
MED/SURG SUPPLY	104,097.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	117,571.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,773.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	54,771.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	219.90	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,012.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,415.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61,869.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,518.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,190.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,185.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,249.80	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	652,093.32	0.00
			TOTAL ACCOMODATIONS	79,050.00	4,550.00
			TOTAL CHARGES	731,143.32	4,550.00

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

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 10/01/16 THROUGH 09/30/17
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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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,401,536.71	ADJUSTMENTS	8,027.92
COVERED CHARGES	1,237,703.58	CONTRACTUAL ALLOW	903,649.33
NON-COVERD CHARGES	163,833.13	TOTAL MEDICAID LIAB	334,054.25
		LESS: COB	138.59
		LESS: COPAYMENT	1,446.00
		REIMBURSEMENT	332,469.66
		ALL OTHER	278,194.19
		FEE SCHEDULE-LAB	27,288.19
		INJECTABLE DRUGS	26,987.28

TOTAL NUMBER OF CLAIMS 1,128

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,057.00	12,682.00	OTHER LAB	31,284.30	0.00
MED/SURG SUPPLY	94,843.00	104.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,476.90	10,139.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	287,652.30	37,756.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	284,811.53	8,108.99
EKG/ECG	13,924.00	118.00	MRI SERVICES	47,859.40	2,340.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,915.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,192.01	5,891.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	14,712.04	2,942.70	CAST ROOM	0.00	0.00
EMERGENCY ROOM	148,600.70	29,932.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	115,137.00	25,250.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,450.00
OTHER IMAGING SERVICE	28,471.60	2,138.50			
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	1,200.00	3,599.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,299.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,807.00	18,377.00			
			TOTAL ANCILLARY	1,237,703.58	163,833.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,237,703.58	163,833.13

Report : CLM-0804-0
Process : CLMJ0800
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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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016333025461	11/16/16 - 11/16/16	12/05/16	0.00	50.00	0.00	0.00	0.00
615	2217081002026	02/17/17 - 02/17/17	03/27/17	0.00	4,400.00	0.00	0.00	0.00
TOTAL				0.00	4,450.00	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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,393.70	ADJUSTMENTS	0.00
COVERED CHARGES	16,347.10	CONTRACTUAL ALLOW	6,510.03
NON-COVERD CHARGES	9,046.60	TOTAL MEDICAID LIAB	9,837.07
		LESS: COB	9,801.07
		LESS: COPAYMENT	36.00
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	590.00	301.00	OTHER LAB	2,419.90	0.00
MED/SURG SUPPLY	1,456.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	762.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,542.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,951.30	56.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,788.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,036.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,022.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,953.00	111.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	286.00	0.00			
			TOTAL ANCILLARY	16,347.10	9,046.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,347.10	9,046.60

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

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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,578.20	ADJUSTMENTS	0.00
COVERED CHARGES	78,181.90	CONTRACTUAL ALLOW	74,144.90
NON-COVERD CHARGES	7,396.30	TOTAL MEDICAID LIAB	4,037.00
		LESS: COB	0.00
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	3,875.00
		TOTAL NUMBER OF CLAIMS	81

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	600.00	286.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,433.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,812.30	910.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,791.40	1,612.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,591.80	717.60
EKG/ECG	590.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	324.70	225.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,784.70	1,316.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,254.00	1,976.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	352.00			
			TOTAL ANCILLARY	78,181.90	7,396.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,181.90	7,396.30

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,266.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,029.00	CONTRACTUAL ALLOW	680.30
NON-COVERD CHARGES	237.00	TOTAL MEDICAID LIAB	1,348.70
		LESS: COB	1,345.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	674.00	107.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	870.00	0.00	SPECIAL SERVICES	0.00	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	130.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,029.00	237.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,029.00	237.00

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: 08/29/2018
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Page: 13

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,314.00	ADJUSTMENTS	0.00
COVERED CHARGES	18,286.00	CONTRACTUAL ALLOW	13,329.59
NON-COVERD CHARGES	1,028.00	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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	729.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,037.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,795.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	444.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,595.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	483.00	146.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	603.00	882.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,286.00	1,028.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,286.00	1,028.00

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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
 Run Time: 00:29:06
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	128,302.30	ADJUSTMENTS	0.00
COVERED CHARGES	125,854.30	CONTRACTUAL ALLOW	9,363.02
NON-COVERD CHARGES	2,448.00	TOTAL MEDICAID LIAB	116,491.28
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	116,491.28

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	46		0	18,400.00		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	46		0	18,400.00		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	46		0	18,400.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,259.00	0.00	OTHER LAB	762.00	0.00
MED/SURG SUPPLY	8,760.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	251.80	0.00
RADIOLOGY-DIAGNOSTIC	3,387.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,072.00	2,448.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	747.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,840.50	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	14,295.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	286.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,446.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,298.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50.00	0.00			
			TOTAL ANCILLARY	107,454.30	2,448.00
			TOTAL ACCOMODATIONS	18,400.00	0.00
			TOTAL CHARGES	125,854.30	2,448.00

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 01/01/17 THROUGH 12/31/17
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: 08/29/2018
Run Time: 00:29:07
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	646,732.52	ADJUSTMENTS	5,311.82
COVERED CHARGES	554,227.77	CONTRACTUAL ALLOW	368,642.82
NON-COVERD CHARGES	92,504.75	TOTAL MEDICAID LIAB	185,584.95
		LESS: COB	512.11
		LESS: COPAYMENT	456.00
		REIMBURSEMENT	184,616.84
		ALL OTHER	148,911.30
		FEE SCHEDULE-LAB	33,945.65
		INJECTABLE DRUGS	1,759.89
		TOTAL NUMBER OF CLAIMS	1,001

JEFFERSON HOSPITAL
 1067 PEACHTREE ST
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,002.00	2,066.00	OTHER LAB	14,084.00	0.00
MED/SURG SUPPLY	10,839.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,426.00	8,505.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,523.00	15,599.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,248.00	661.00	FEE SCHEDULE LAB	174,924.00	9,487.00
EKG/ECG	7,861.50	4,159.50	MRI SERVICES	3,172.00	0.00
IV THERAPY	1,779.00	3,819.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,550.00	22,303.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,540.50	3,181.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,948.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,906.00	13,804.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,563.00	2,106.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,667.00	819.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,966.00	2,414.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,600.00	1,181.00			
BLOOD	603.00	0.00			
BLOOD STORAGE & PRO.	603.00	781.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,450.00	1,618.75			
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	972.00	0.00			
			TOTAL ANCILLARY	554,227.77	92,504.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	554,227.77	92,504.75

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,478.75	ADJUSTMENTS	0.00
COVERED CHARGES	8,889.00	CONTRACTUAL ALLOW	1,803.19
NON-COVERD CHARGES	4,589.75	TOTAL MEDICAID LIAB	7,085.81
		LESS: COB	7,082.81
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189.00	162.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	584.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	414.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	694.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,115.00	97.00
EKG/ECG	0.00	244.50	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	558.00	645.25	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	2,920.00	1,622.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	179.00	269.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	554.00	162.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	790.00	280.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,889.00	4,589.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,889.00	4,589.75

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,979.75	ADJUSTMENTS	167.82
COVERED CHARGES	70,881.75	CONTRACTUAL ALLOW	63,777.37
NON-COVERD CHARGES	7,098.00	TOTAL MEDICAID LIAB	7,104.38
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	6,912.38
		TOTAL NUMBER OF CLAIMS	127

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	474.00	69.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	441.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,389.00	276.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,978.00	4,366.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,335.00	740.00
EKG/ECG	1,798.00	569.50	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	317.25	292.50	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	41,431.50	585.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,420.00	200.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	298.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	70,881.75	7,098.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,881.75	7,098.00

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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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

JEFFERSON HOSPITAL
1067 PEACHTREE ST
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER
000001031A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GA MEDICAL HOLDINGS CORP LLC
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 06/15/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,844.64	ADJUSTMENTS	0.00
COVERED CHARGES	29,691.94	CONTRACTUAL ALLOW	11,393.61
NON-COVERD CHARGES	21,152.70	TOTAL MEDICAID LIAB	18,298.33
		LESS: COB	509.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,788.94

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	9,240.00		20,760.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	9,240.00		20,760.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	10		0	9,240.00		20,760.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GA MEDICAL HOLDINGS CORP LLC
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 06/15/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,507.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,996.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,513.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,148.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	215.13	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	344.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	740.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,030.63	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,116.40	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.	728.00	392.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,451.94	392.70
			TOTAL ACCOMODATIONS	9,240.00	20,760.00
			TOTAL CHARGES	29,691.94	21,152.70

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

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	06/15/17
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: 08/29/2018
Run Time: 00:50:58
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GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 06/15/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	545,576.61	ADJUSTMENTS	22,438.42
COVERED CHARGES	499,952.60	CONTRACTUAL ALLOW	374,355.43
NON-COVERD CHARGES	45,624.01	TOTAL MEDICAID LIAB	125,597.17
		LESS: COB	7.07
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	125,308.10
		ALL OTHER	89,749.43
		FEE SCHEDULE-LAB	35,547.68
		INJECTABLE DRUGS	10.99

TOTAL NUMBER OF CLAIMS 735

GA MEDICAL HOLDINGS CORP LLC
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 06/15/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,276.20	0.00	OTHER LAB	533.55	0.00
MED/SURG SUPPLY	2,745.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	123.00	EDUCATION & TRAINING	0.00	47.72
RADIOLOGY-DIAGNOSTIC	15,268.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,124.95	1,533.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,464.23	32,883.87	FEE SCHEDULE LAB	208,395.63	3,141.28
EKG/ECG	5,345.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,822.67	333.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,374.33	4,322.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,905.08	236.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	69,871.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39.95	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	3,956.05	0.00			
BLOOD	1,149.40	0.00			
BLOOD STORAGE & PRO.	1,820.00	392.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,568.50	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	16,290.49	2,609.24			
			TOTAL ANCILLARY	499,952.60	45,624.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	499,952.60	45,624.01

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

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

Run Date: 08/29/2018
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	06/15/17
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: 08/29/2018
Run Time: 00:50:59
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GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 06/15/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,532.48	ADJUSTMENTS	144.00
COVERED CHARGES	20,736.49	CONTRACTUAL ALLOW	19,186.49
NON-COVERD CHARGES	1,795.99	TOTAL MEDICAID LIAB	1,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	1,481.00
		TOTAL NUMBER OF CLAIMS	31

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

GA MEDICAL HOLDINGS CORP LLC
 931 E WINTHROPE AVE
 MILLEN,GA 30442-1839

PROVIDER NUMBER
 000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 06/15/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,498.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12.64	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	3,786.70	1,074.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,595.92	216.44
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,964.68	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	8,519.70	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	505.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,736.49	1,795.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,736.49	1,795.99

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: 08/29/2018
Run Time: 00:51:00
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GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	06/15/17
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: 08/29/2018
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	06/15/17
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: 08/29/2018
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Page: 11

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GA MEDICAL HOLDINGS CORP LLC
931 E WINTHROPE AVE
MILLEN,GA 30442-1839

PROVIDER NUMBER
000001042A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	06/15/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER-DULUTH
 3620 HOWELL FERRY RD
 DULUTH,GA 30096-3178

PROVIDER NUMBER 000001064A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,952,555.00	ADJUSTMENTS	361,844.94
COVERED CHARGES	14,589,791.00	CONTRACTUAL ALLOW	10,431,460.73
NON-COVERD CHARGES	1,362,764.00	TOTAL MEDICAID LIAB	4,158,330.27
		LESS: COB	82,673.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,075,657.21

TOTAL NUMBER OF ADMISSIONS 429

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,014		0	2,616,702.00		1,162,651.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,014		0	2,616,702.00		1,162,651.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	578		0	1,661,928.00		7,839.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	578		0	1,661,928.00		7,839.00
TOTAL ACCOMODATIONS	2,592		0	4,278,630.00		1,170,490.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,020,856.20	46,287.00	OTHER LAB	107,033.00	3,266.00
MED/SURG SUPPLY	83,853.00	818.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,199,046.00	20,171.00	EDUCATION & TRAINING	4,049.00	0.00
RADIOLOGY-DIAGNOSTIC	415,496.00	5,117.00	OTHER THERAPEUTIC SVC	455.00	0.00
CT SCAN	1,057,093.00	29,125.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,078.00	873.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	175,562.00	2,508.00	MRI SERVICES	149,107.00	0.00
IV THERAPY	537,505.00	321.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,297,857.00	98.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	576,128.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	282,857.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	96,361.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	992,625.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	196,093.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	98,628.00	0.00	INJECTABLE DRUGS	726,555.14	1,502.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,099.00	713.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,011.66	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	311,345.00	41,470.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	923.00	2,391.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	231,466.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	36,520.00
OTHER IMAGING SERVICE	94,457.00	1,094.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	47,178.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	164,390.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	234,086.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,871.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	88,097.00	0.00			
			TOTAL ANCILLARY	10,311,161.00	192,274.00
			TOTAL ACCOMODATIONS	4,278,630.00	1,170,490.00
			TOTAL CHARGES	14,589,791.00	1,362,764.00

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-DULUTH
 3620 HOWELL FERRY RD
 DULUTH,GA 30096-3178

PROVIDER NUMBER
 000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016351009355	11/30/16 - 12/06/16	12/19/16	0.00	4,565.00	0.00	0.00	0.00
615	2017019101346	07/19/16 - 07/27/16	01/23/17	0.00	4,565.00	0.00	0.00	0.00
615	2317061000138	11/10/16 - 11/30/16	03/20/17	0.00	4,565.00	0.00	4,738.16	0.00
615	2017069005338	02/19/17 - 02/24/17	03/13/17	0.00	4,565.00	0.00	0.00	0.00
615	2317074000300	12/17/16 - 12/18/16	03/27/17	0.00	4,565.00	0.00	781.94	0.00
615	2017206076080	04/23/17 - 04/26/17	07/31/17	0.00	4,565.00	0.00	0.00	0.00
615	9717332951011	02/01/17 - 03/01/17	12/04/17	0.00	4,565.00	0.00	0.00	0.00
615	2317341000013	03/20/17 - 03/22/17	01/08/18	0.00	4,565.00	0.00	0.00	0.00
TOTAL				0.00	36,520.00	0.00	5,520.10	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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,553.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,281.00	CONTRACTUAL ALLOW	6,605.90
NON-COVERD CHARGES	7,272.00	TOTAL MEDICAID LIAB	16,675.10
		LESS: COB	16,675.10
		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	8		0	12,056.00		7,272.00
ROUTINE NURSERY	0		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	12,056.00		7,272.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	12,056.00		7,272.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,496.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,628.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,008.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	670.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,176.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,235.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,225.00	0.00
			TOTAL ACCOMODATIONS	12,056.00	7,272.00
			TOTAL CHARGES	23,281.00	7,272.00

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: 08/29/2018
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WINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,967,107.50	ADJUSTMENTS	180,129.88
COVERED CHARGES	6,105,049.40	CONTRACTUAL ALLOW	5,095,070.02
NON-COVERD CHARGES	862,058.10	TOTAL MEDICAID LIAB	1,009,979.38
		LESS: COB	499.47
		LESS: COPAYMENT	1,395.83
		REIMBURSEMENT	1,008,084.08
		ALL OTHER	918,590.34
		FEE SCHEDULE-LAB	76,057.12
		INJECTABLE DRUGS	13,436.62
		TOTAL NUMBER OF CLAIMS	1,890

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

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

Run Date: 08/29/2018
 Run Time: 00:26:05
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GWINNETT MEDICAL CENTER-DULUTH
 3620 HOWELL FERRY RD
 DULUTH,GA 30096-3178

PROVIDER NUMBER
 000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,822.00	147.00	OTHER LAB	66,071.00	0.00
MED/SURG SUPPLY	35,307.00	9,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	734.00
RADIOLOGY-DIAGNOSTIC	375,145.00	11,231.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	850,927.00	328,974.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	428.00	909.00	FEE SCHEDULE LAB	725,487.00	9,727.00
EKG/ECG	113,986.00	0.00	MRI SERVICES	101,815.00	62,678.00
IV THERAPY	398,159.00	7,824.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	558,159.40	176,911.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,478.00	3,211.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	228,079.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	160,880.50	37,629.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,564,461.00	6,397.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	189,069.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	194,491.50	36,321.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	441.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	895.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	31,900.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,596.00	426.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,668.00	33,316.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,565.00
OTHER IMAGING SERVICE	150,611.00	44,103.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,135.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,116.00	37,998.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	52,040.00	16,463.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,118.00	0.00			
			TOTAL ANCILLARY	6,105,049.40	862,058.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,105,049.40	862,058.10

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

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

Run Date: 08/29/2018
Run Time: 00:26:05
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GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216287013311	07/22/16 - 07/22/16	10/17/16	0.00	2,481.00	0.00	0.00	0.00
615	2216287013311	07/22/16 - 07/22/16	10/17/16	0.00	2,084.00	0.00	0.00	0.00
TOTAL				0.00	4,565.00	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: 08/29/2018
Run Time: 00:26:12
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,596.00	ADJUSTMENTS	0.00
COVERED CHARGES	18,414.00	CONTRACTUAL ALLOW	9,124.81
NON-COVERD CHARGES	10,182.00	TOTAL MEDICAID LIAB	9,289.19
		LESS: COB	9,280.19
		LESS: COPAYMENT	9.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	475.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	393.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,761.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,711.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,618.00	29.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,001.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,072.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	338.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,042.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,601.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	511.00	173.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,080.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	995.00	381.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,415.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,414.00	10,182.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,414.00	10,182.00

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: 08/29/2018
Run Time: 00:26:12
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	507,422.50	ADJUSTMENTS	320.64
COVERED CHARGES	473,537.50	CONTRACTUAL ALLOW	459,888.14
NON-COVERD CHARGES	33,885.00	TOTAL MEDICAID LIAB	13,649.36
		LESS: COB	50.40
		LESS: COPAYMENT	400.35
		REIMBURSEMENT	13,198.61
		TOTAL NUMBER OF CLAIMS	244

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,755.00	0.00	OTHER LAB	1,927.00	0.00
MED/SURG SUPPLY	734.00	145.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,785.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	59,085.00	27,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	70,782.00	114.00
EKG/ECG	7,106.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,590.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,400.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	845.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	225,636.00	354.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,476.50	197.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	792.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,416.00	4,483.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	473,537.50	33,885.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	473,537.50	33,885.00

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,704.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,704.00	CONTRACTUAL ALLOW	5,800.93
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	8,903.07
		LESS: COB	8,897.07
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76.00	0.00	OTHER LAB	1,633.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,957.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,746.00	0.00
EKG/ECG	1,254.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,021.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,778.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	735.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,704.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,704.00	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: 08/29/2018
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	259,494.00	ADJUSTMENTS	55,237.70
COVERED CHARGES	255,677.00	CONTRACTUAL ALLOW	183,832.89
NON-COVERD CHARGES	3,817.00	TOTAL MEDICAID LIAB	71,844.11
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	71,808.11

TOTAL NUMBER OF CLAIMS 13

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,409.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,414.00	570.00
EKG/ECG	418.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,914.00	1,022.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,244.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,570.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,614.00	99.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,087.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	183,773.00	2,126.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	670.00	0.00			
			TOTAL ANCILLARY	255,677.00	3,817.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	255,677.00	3,817.00

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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH
3620 HOWELL FERRY RD
DULUTH,GA 30096-3178

PROVIDER NUMBER
000001064A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:37:04
 Page: 1

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,084,173.57	ADJUSTMENTS	410,353.77
COVERED CHARGES	11,927,147.55	CONTRACTUAL ALLOW	8,543,017.52
NON-COVERD CHARGES	157,026.02	TOTAL MEDICAID LIAB	3,384,130.03
		LESS: COB	14,539.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,369,590.64

TOTAL NUMBER OF ADMISSIONS 548

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	987		0	810,680.00		48,000.00
ROUTINE NURSERY	244		0	193,360.00		7,610.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,231		0	1,004,040.00		55,610.00
SPECIAL CARE SERVICES						
CCU	279		0	419,200.00		0.00
ICU	166		0	332,532.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	445		0	751,732.00		0.00
TOTAL ACCOMODATIONS	1,676		0	1,755,772.00		55,610.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	518,914.49	0.00	OTHER LAB	85,871.75	0.00
MED/SURG SUPPLY	557,064.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,710,668.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	215,081.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	653,471.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,232.50	0.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	235,006.50	0.00	MRI SERVICES	37,932.25	0.00
IV THERAPY	12,345.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,941,562.50	2,768.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	397,174.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	412,431.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	262,108.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	715,380.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	134,815.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	864,585.27	0.00
RADIOLOGY THERAPEUTIC	29,354.82	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,579.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,442.50	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	3,782.00	16,170.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	257,194.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,474.00
OTHER IMAGING SERVICE	73,760.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	132,132.50	65,960.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	81,242.50	14,044.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	744,079.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,170.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,991.75	0.00			
			TOTAL ANCILLARY	10,171,375.55	101,416.02
			TOTAL ACCOMODATIONS	1,755,772.00	55,610.00
			TOTAL CHARGES	11,927,147.55	157,026.02

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: 08/29/2018
Run Time: 00:37:04
Page: 3

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016277030807	09/07/16 - 09/09/16	10/10/16	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	2,474.00	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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
Run Time: 00:37:09
Page: 5

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,573,454.81	ADJUSTMENTS	292,328.19
COVERED CHARGES	15,195,215.12	CONTRACTUAL ALLOW	12,820,912.06
NON-COVERD CHARGES	1,378,239.69	TOTAL MEDICAID LIAB	2,374,303.06
		LESS: COB	1,715.93
		LESS: COPAYMENT	9,506.72
		REIMBURSEMENT	2,363,080.41
		ALL OTHER	2,050,305.74
		FEE SCHEDULE-LAB	143,022.57
		INJECTABLE DRUGS	169,752.10

TOTAL NUMBER OF CLAIMS 5,227

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,134.65	4,184.55	OTHER LAB	90,054.75	0.00
MED/SURG SUPPLY	384,649.39	44,185.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	168.75	EDUCATION & TRAINING	183.75	60.50
RADIOLOGY-DIAGNOSTIC	662,958.50	25,956.75	OTHER THERAPEUTIC SVC	0.00	183.75
CT SCAN	2,057,153.25	147,001.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	62,099.00	10,641.00	FEE SCHEDULE LAB	1,803,810.40	52,434.50
EKG/ECG	207,191.25	2,522.00	MRI SERVICES	628,652.25	18,561.25
IV THERAPY	141,561.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,101,806.25	212,729.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,380.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	206,105.00	124,892.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	333,053.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,372,192.26	17,680.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	178,816.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	230,827.29	70,913.67
RADIOLOGY THERAPEUTIC	456,769.89	141,283.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,193.25	2,642.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,613.00	2,166.50	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	534,580.08	8,589.52	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	83,332.32	58,779.85
LITHOTRIPSY	190,264.50	0.00	NO CC/INVALID REV CODE	0.00	7,388.75
OTHER IMAGING SERVICE	446,451.50	48,469.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,962.45	1,306.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	452,635.25	145,584.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	543,253.25	147,925.50			
AMBULATORY SURGERY	188,231.50	62,534.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	199,110.00	682.75			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	486,189.00	18,771.75			
			TOTAL ANCILLARY	15,195,215.12	1,378,239.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,195,215.12	1,378,239.69

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916257002368	08/26/16 - 08/26/16	09/19/16	0.00	2,440.75	0.00	0.00	0.00
615	2016349054907	10/04/16 - 10/04/16	12/19/16	0.00	2,474.00	0.00	0.00	0.00
615	2017024074587	01/16/17 - 01/16/17	01/30/17	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	7,388.75	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

Run Date: 08/29/2018
Run Time: 00:37:30
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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER
1 MEADOWS PKWY
VIDALIA,GA 30474-8759

PROVIDER NUMBER
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,176.84	ADJUSTMENTS	0.00
COVERED CHARGES	21,873.46	CONTRACTUAL ALLOW	14,862.64
NON-COVERD CHARGES	8,303.38	TOTAL MEDICAID LIAB	7,010.82
		LESS: COB	6,999.02
		LESS: COPAYMENT	11.80
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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

MEADOWS REGIONAL MEDICAL CENTER
 1 MEADOWS PKWY
 VIDALIA,GA 30474-8759

PROVIDER NUMBER
 000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123.26	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	885.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	57.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	660.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,491.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,365.75	165.00
EKG/ECG	1,261.00	0.00	MRI SERVICES	0.00	3,166.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	141.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	250.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,647.25	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	71.84	322.13
RADIOLOGY THERAPEUTIC	308.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	612.75	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	173.25	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	2,380.25	4,592.75			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,873.46	8,303.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,873.46	8,303.38

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	863,060.46	ADJUSTMENTS	529.40
COVERED CHARGES	843,452.70	CONTRACTUAL ALLOW	813,580.74
NON-COVERD CHARGES	19,607.76	TOTAL MEDICAID LIAB	29,871.96
		LESS: COB	0.00
		LESS: COPAYMENT	1,139.18
		REIMBURSEMENT	28,732.78
		TOTAL NUMBER OF CLAIMS	534

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,279.44	35.00	OTHER LAB	2,633.75	0.00
MED/SURG SUPPLY	4,759.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,457.00	1,360.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	115,230.25	10,175.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	240.50	442.50	FEE SCHEDULE LAB	152,255.75	4,080.25
EKG/ECG	22,382.75	0.00	MRI SERVICES	4,291.00	0.00
IV THERAPY	15,260.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	987.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	432,174.55	328.25	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	22,219.08	213.26
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	224.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	210.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,025.00	2,748.75			
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	2,047.50	0.00			
			TOTAL ANCILLARY	843,452.70	19,607.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	843,452.70	19,607.76

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,110,541.06	ADJUSTMENTS	46,719.48
COVERED CHARGES	1,034,925.34	CONTRACTUAL ALLOW	835,972.30
NON-COVERD CHARGES	75,615.72	TOTAL MEDICAID LIAB	198,953.04
		LESS: COB	0.00
		LESS: COPAYMENT	460.20
		REIMBURSEMENT	198,492.84

TOTAL NUMBER OF CLAIMS 34

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,510.74	70.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38,921.39	17,393.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,111.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,764.50	54.00
EKG/ECG	1,325.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,003.00	2,725.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	213,362.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	285,095.00	131.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,337.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	465.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,021.54	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	143,731.04	1,405.65
RADIOLOGY THERAPEUTIC	22,902.50	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	15,617.75	1,022.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,552.88	50,442.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,184.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	86,081.75	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	75,937.00	2,371.75			
			TOTAL ANCILLARY	1,034,925.34	75,615.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,034,925.34	75,615.72

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

Run Date: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 00:01:00
 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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	151,946,769.15	ADJUSTMENTS	5,784,680.00
COVERED CHARGES	146,284,019.16	CONTRACTUAL ALLOW	118,711,506.49
NON-COVERD CHARGES	5,662,749.99	TOTAL MEDICAID LIAB	27,572,512.67
		LESS: COB	329,165.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,243,346.85

TOTAL NUMBER OF ADMISSIONS 2,637

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,914		0	10,380,930.00		1,353,918.00
ROUTINE NURSERY	2,088		0	2,739,326.00		118,463.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11,002		0	13,120,256.00		1,472,381.00
SPECIAL CARE SERVICES						
CCU	3,397		0	8,116,217.00		371,922.00
ICU	2,296		0	7,145,115.00		254,065.00
NICU	819		0	2,692,163.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	32		0	165,248.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,544		0	18,118,743.00		625,987.00
TOTAL ACCOMODATIONS	17,546		0	31,238,999.00		2,098,368.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,906,716.59	659,455.20	OTHER LAB	1,218,787.00	142,117.00
MED/SURG SUPPLY	6,972,375.80	210,193.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,116,624.50	332,249.00	EDUCATION & TRAINING	44,899.00	0.00
RADIOLOGY-DIAGNOSTIC	3,112,108.00	102,620.00	OTHER THERAPEUTIC SVC	0.00	29,877.00
CT SCAN	8,556,937.00	232,440.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,293,389.82	87,278.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	893,542.00	7,477.00	MRI SERVICES	1,935,210.00	15,489.00
IV THERAPY	1,346,589.00	33,568.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,482,493.20	349,440.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,747,574.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,322,862.50	155,898.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,086,992.20	66,049.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,622,849.00	2,241.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,878,701.00	37,057.00	DRUG-SPECIFIC/HOME IV	0.00	7,207.50
LABORATORY PATHOLOGIC	538,212.00	1,631.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	490,146.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	582,533.38	30,406.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	486,045.63	37,406.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,450,232.00	449,100.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	97,014.00	19,019.00	TRAUMA RESPONSE	0.00	131,830.00
PSYCHIATRIC SERVICES	9,559.00	0.00	IMPL DEV CHARGE PATIENTS	4,207,048.96	107,944.24
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	673,848.00	19,269.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,895,258.00	212,821.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	547,554.00	9,350.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,932,263.50	11,458.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	486,270.00	28,494.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,110,385.08	34,998.00			
			TOTAL ANCILLARY	115,045,020.16	3,564,381.99
			TOTAL ACCOMODATIONS	31,238,999.00	2,098,368.00
			TOTAL CHARGES	146,284,019.16	5,662,749.99

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

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

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,450,758.73	ADJUSTMENTS	0.00
COVERED CHARGES	3,417,978.73	CONTRACTUAL ALLOW	1,676,782.19
NON-COVERD CHARGES	32,780.00	TOTAL MEDICAID LIAB	1,741,196.54
		LESS: COB	1,741,196.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 103

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	252		0	309,960.00		15,736.00
ROUTINE NURSERY	139		0	251,570.00		17,044.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	391		0	561,530.00		32,780.00
SPECIAL CARE SERVICES						
CCU	132		0	326,613.00		0.00
ICU	13		0	38,561.00		0.00
NICU	53		0	173,893.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	198		0	539,067.00		0.00
TOTAL ACCOMODATIONS	589		0	1,100,597.00		32,780.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	304,722.25	0.00	OTHER LAB	16,168.00	0.00
MED/SURG SUPPLY	96,670.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	321,433.00	0.00	EDUCATION & TRAINING	10,222.00	0.00
RADIOLOGY-DIAGNOSTIC	34,081.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,782.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,269.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,581.00	0.00	MRI SERVICES	20,685.00	0.00
IV THERAPY	23,657.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	248,575.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	506,395.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	137,129.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	74,769.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,545.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	79,708.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	16,117.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,112.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	35,928.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,219.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	101,905.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,896.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,412.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50,241.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,222.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,936.75	0.00			
			TOTAL ANCILLARY	2,317,381.73	0.00
			TOTAL ACCOMODATIONS	1,100,597.00	32,780.00
			TOTAL CHARGES	3,417,978.73	32,780.00

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,801,265.85	ADJUSTMENTS	497,785.60
COVERED CHARGES	33,856,398.56	CONTRACTUAL ALLOW	29,449,557.45
NON-COVERD CHARGES	2,944,867.29	TOTAL MEDICAID LIAB	4,406,841.11
		LESS: COB	73,387.95
		LESS: COPAYMENT	8,281.18
		REIMBURSEMENT	4,325,171.98
		ALL OTHER	3,904,614.29
		FEE SCHEDULE-LAB	406,399.12
		INJECTABLE DRUGS	14,158.57
		TOTAL NUMBER OF CLAIMS	9,640

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	876,046.25	13,086.00	OTHER LAB	794,791.00	0.00
MED/SURG SUPPLY	659,647.90	56,602.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	140.08	EDUCATION & TRAINING	0.00	574.00
RADIOLOGY-DIAGNOSTIC	1,502,097.00	12,334.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,435,700.00	561,899.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	190,921.00	59,813.01	FEE SCHEDULE LAB	5,237,260.36	224,240.72
EKG/ECG	446,445.00	6,705.00	MRI SERVICES	1,450,340.00	208,223.00
IV THERAPY	1,481,480.00	10,740.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,043,916.00	329,882.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	154,752.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	166,044.00	98,585.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,110,685.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,560,628.00	9,878.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	642,798.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,029.75
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	80,723.26	63,425.63
RADIOLOGY THERAPEUTIC	644,660.00	43,863.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	82,584.00	15,210.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,724.00	4,954.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	65,868.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	352,692.00	34,252.00	TRAUMA RESPONSE	0.00	39,144.00
PSYCHIATRIC SERVICES	62,403.00	147,791.00	IMPL DEV CHARGE PATIENTS	205,440.57	90,441.94
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	840.00
OTHER IMAGING SERVICE	1,336,964.00	428,181.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,043.00	1,471.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	542,115.50	90,862.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	822,944.00	306,796.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	197,247.00	1,542.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	686,306.72	16,494.00			
			TOTAL ANCILLARY	33,856,398.56	2,944,867.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,856,398.56	2,944,867.29

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

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8836	5917110000239	01/18/17 - 01/18/17	04/24/17	0.00	840.00	0.00	0.00	0.00
TOTAL				0.00	840.00	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 KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	754,965.44	ADJUSTMENTS	0.00
COVERED CHARGES	622,740.90	CONTRACTUAL ALLOW	358,441.47
NON-COVERD CHARGES	132,224.54	TOTAL MEDICAID LIAB	264,299.43
		LESS: COB	264,168.66
		LESS: COPAYMENT	130.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 179

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 07/01/16 THROUGH 06/30/17
 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	16,824.84	1,155.00	OTHER LAB	31,641.00	0.00
MED/SURG SUPPLY	13,182.84	497.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	30.00
RADIOLOGY-DIAGNOSTIC	17,713.00	3,584.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,246.00	46,378.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107,113.22	2,681.52
EKG/ECG	5,377.00	0.00	MRI SERVICES	25,109.00	8,341.00
IV THERAPY	36,545.00	185.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	40,208.00	36,358.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	24,759.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,784.00	1,081.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,762.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	122,488.00	1,174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,870.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	407.50	215.50
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	8,517.00	1,654.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	638.00	IMPL DEV CHARGE PATIENTS	4,162.88	11,510.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,144.00	9,221.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,028.00	520.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,744.00	7,001.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,626.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,488.62	0.00			
			TOTAL ANCILLARY	622,740.90	132,224.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	622,740.90	132,224.54

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,236,625.30	ADJUSTMENTS	547.40
COVERED CHARGES	1,174,463.30	CONTRACTUAL ALLOW	1,145,416.73
NON-COVERD CHARGES	62,162.00	TOTAL MEDICAID LIAB	29,046.57
		LESS: COB	2,229.83
		LESS: COPAYMENT	696.00
		REIMBURSEMENT	26,120.74
		TOTAL NUMBER OF CLAIMS	480

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,573.25	0.00	OTHER LAB	45,901.00	0.00
MED/SURG SUPPLY	4,102.60	330.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,697.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	113,435.00	6,154.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	228,203.00	8,370.00
EKG/ECG	14,304.00	0.00	MRI SERVICES	4,678.00	6,074.00
IV THERAPY	65,884.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,113.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,580.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,456.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	534,633.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,177.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,043.75	135.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	5,153.00	15,476.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,203.00	22,259.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,253.00			
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	5,326.70	0.00			
			TOTAL ANCILLARY	1,174,463.30	62,162.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,174,463.30	62,162.00

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 KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,527.50	ADJUSTMENTS	0.00
COVERED CHARGES	52,301.50	CONTRACTUAL ALLOW	37,289.48
NON-COVERD CHARGES	12,226.00	TOTAL MEDICAID LIAB	15,012.02
		LESS: COB	14,996.02
		LESS: COPAYMENT	16.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

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 KENNESTONE HOSPITAL
 677 CHURCH ST NE
 MARIETTA,GA 30060-1101

PROVIDER NUMBER
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,109.50	600.00	OTHER LAB	3,882.00	0.00
MED/SURG SUPPLY	175.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,323.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,154.00	6,154.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,302.00	36.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,776.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,309.00	1,898.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,271.00	3,538.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	52,301.50	12,226.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,301.50	12,226.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,558,008.28	ADJUSTMENTS	93,500.40
COVERED CHARGES	3,342,989.93	CONTRACTUAL ALLOW	3,095,210.93
NON-COVERD CHARGES	215,018.35	TOTAL MEDICAID LIAB	247,779.00
		LESS: COB	0.00
		LESS: COPAYMENT	483.00
		REIMBURSEMENT	247,296.00

TOTAL NUMBER OF CLAIMS 45

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,438.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	201,938.92	18,976.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,110.00	10,230.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,762.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,662.00	0.00
EKG/ECG	1,341.00	447.00	MRI SERVICES	0.00	0.00
IV THERAPY	637.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	399,872.34	26,236.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,264.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	138,679.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,941.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,300.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,066.00	21,441.25
RADIOLOGY THERAPEUTIC	1,439,753.00	4,341.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,430.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	709,735.12	91,138.96
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,575.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,693.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	267,555.00	42,207.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,236.65	0.00			
			TOTAL ANCILLARY	3,342,989.93	215,018.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,342,989.93	215,018.35

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 KENNESTONE HOSPITAL
677 CHURCH ST NE
MARIETTA,GA 30060-1101

PROVIDER NUMBER
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	158,677.21	ADJUSTMENTS	0.00
COVERED CHARGES	157,270.21	CONTRACTUAL ALLOW	90,450.16
NON-COVERD CHARGES	1,407.00	TOTAL MEDICAID LIAB	66,820.05
		LESS: COB	66,811.05
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR KENNESTONE HOSPITAL
 677 CHURCH ST NE
 MARIETTA,GA 30060-1101

PROVIDER NUMBER
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,040.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,045.00	21.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,978.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,547.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,688.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,093.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	1,386.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	98,920.80	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	957.91	0.00			
			TOTAL ANCILLARY	157,270.21	1,407.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	157,270.21	1,407.00

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

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

Run Date: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,054,020.17	ADJUSTMENTS	327,017.56
COVERED CHARGES	30,346,655.27	CONTRACTUAL ALLOW	25,296,891.38
NON-COVERD CHARGES	707,364.90	TOTAL MEDICAID LIAB	5,049,763.89
		LESS: COB	69,512.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,980,251.59

TOTAL NUMBER OF ADMISSIONS 598

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,144		0	2,052,741.00		209,883.00
ROUTINE NURSERY	136		0	102,189.00		2,680.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,280		0	2,154,930.00		212,563.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	461		0	1,234,188.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	461		0	1,234,188.00		0.00
TOTAL ACCOMODATIONS	2,741		0	3,389,118.00		212,563.00

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,356,754.11	0.00	OTHER LAB	142,590.50	0.00
MED/SURG SUPPLY	1,737,125.55	449.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,888,501.98	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	597,292.55	0.00	OTHER THERAPEUTIC SVC	0.00	21,909.00
CT SCAN	1,226,837.00	263,008.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	505,545.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	256,575.00	0.00	MRI SERVICES	227,175.00	0.00
IV THERAPY	8,643.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,175,809.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	220,778.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,071,605.50	65.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	187,959.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	86,474.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	944,621.00	567.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	227,295.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	64,766.00
LABORATORY PATHOLOGIC	61,195.00	0.00	INJECTABLE DRUGS	6,570,677.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	365,036.95	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	59,303.07	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	269,820.00	11,743.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,466.75	1,965.00	TRAUMA RESPONSE	0.00	9,800.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	489,403.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	201,771.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	79,376.13	119,623.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	256,683.00	906.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,579,907.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,704.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	136,610.80	0.00			
			TOTAL ANCILLARY	26,957,537.27	494,801.90
			TOTAL ACCOMODATIONS	3,389,118.00	212,563.00
			TOTAL CHARGES	30,346,655.27	707,364.90

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: 08/29/2018
Run Time: 00:36:27
Page: 3

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	2017097065290	03/30/17 - 03/31/17	04/17/17	0.00	0.00	0.00	0.00	0.00
24	2017109075524	03/03/17 - 03/25/17	04/24/17	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	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: 08/29/2018
 Run Time: 00:36:33
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	282,685.90	ADJUSTMENTS	0.00
COVERED CHARGES	277,724.90	CONTRACTUAL ALLOW	190,857.28
NON-COVERD CHARGES	4,961.00	TOTAL MEDICAID LIAB	86,867.62
		LESS: COB	86,867.62
		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	29		0	28,024.00		2,852.00
ROUTINE NURSERY	3		0	2,389.00		179.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	32		0	30,413.00		3,031.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,716.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	2,716.00		0.00
TOTAL ACCOMODATIONS	33		0	33,129.00		3,031.00

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,879.75	0.00	OTHER LAB	3,601.00	0.00
MED/SURG SUPPLY	11,637.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,875.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,324.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,966.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,169.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,101.00	0.00	MRI SERVICES	11,956.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,643.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,030.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	139.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,171.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,818.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,032.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,177.00	0.00	INJECTABLE DRUGS	67,463.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	506.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	932.56	1,930.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,173.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	244,595.90	1,930.00
			TOTAL ACCOMODATIONS	33,129.00	3,031.00
			TOTAL CHARGES	277,724.90	4,961.00

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: 08/29/2018
Run Time: 00:36:34
Page: 6

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,679,542.23	ADJUSTMENTS	47,182.64
COVERED CHARGES	21,123,875.00	CONTRACTUAL ALLOW	19,540,983.51
NON-COVERD CHARGES	1,555,667.23	TOTAL MEDICAID LIAB	1,582,891.49
		LESS: COB	812.71
		LESS: COPAYMENT	4,009.14
		REIMBURSEMENT	1,578,069.64
		ALL OTHER	1,377,603.67
		FEE SCHEDULE-LAB	186,903.18
		INJECTABLE DRUGS	13,562.79
		TOTAL NUMBER OF CLAIMS	4,676

FAIRVIEW PARK HOSPITAL
 200 INDUSTRIAL BLVD
 DUBLIN,GA 31021-2981

PROVIDER NUMBER
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	268,492.04	325.25	OTHER LAB	143,332.00	0.00
MED/SURG SUPPLY	961,407.80	3,014.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,170,428.00	35,095.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,022,862.00	261,225.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	152,791.25	18,067.00	FEE SCHEDULE LAB	5,218,233.75	309,043.00
EKG/ECG	393,525.00	1,154.00	MRI SERVICES	328,736.00	16,502.00
IV THERAPY	418,002.80	5,040.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,596,502.42	278,030.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	29,012.00	944.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134,561.02	149,817.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	486,495.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	231,147.26	94,598.74	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,138,676.00	14,577.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	220,422.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	153,388.08	56,998.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,472.25	7,326.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,915.25	6,865.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,040.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	62,085.75	9,169.00	TRAUMA RESPONSE	0.00	49,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	179,030.10	16,542.70
LITHOTRIpsy	140,353.00	28,721.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	504,025.75	37,033.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,548.98	22,230.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	150,002.00	32,131.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	455,904.00	48,987.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	170,547.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	338,976.50	50,188.00			
			TOTAL ANCILLARY	21,123,875.00	1,555,667.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,123,875.00	1,555,667.23

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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	589,473.64	ADJUSTMENTS	0.00
COVERED CHARGES	444,397.09	CONTRACTUAL ALLOW	287,487.24
NON-COVERD CHARGES	145,076.55	TOTAL MEDICAID LIAB	156,909.85
		LESS: COB	156,870.85
		LESS: COPAYMENT	39.00
		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

FAIRVIEW PARK HOSPITAL
 200 INDUSTRIAL BLVD
 DUBLIN,GA 31021-2981

PROVIDER NUMBER
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,051.19	0.00	OTHER LAB	5,432.25	0.00
MED/SURG SUPPLY	59,131.40	2,038.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,049.00	1,593.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,810.00	7,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	113,141.75	5,818.25
EKG/ECG	5,505.00	524.00	MRI SERVICES	0.00	5,978.00
IV THERAPY	5,268.00	177.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,825.00	84,378.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	944.00	2,491.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,405.50	2,093.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	33,496.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,293.00	1,261.00	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	3,905.50	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	10,897.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,380.25	6,464.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	503.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,158.00	869.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	23,140.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,964.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,766.00	350.00			
			TOTAL ANCILLARY	444,397.09	145,076.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	444,397.09	145,076.55

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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,234,547.39	ADJUSTMENTS	167.82
COVERED CHARGES	1,185,200.34	CONTRACTUAL ALLOW	1,163,215.92
NON-COVERD CHARGES	49,347.05	TOTAL MEDICAID LIAB	21,984.42
		LESS: COB	0.00
		LESS: COPAYMENT	726.00
		REIMBURSEMENT	21,258.42
		TOTAL NUMBER OF CLAIMS	393

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,078.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,714.80	373.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	92,265.50	1,777.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	240,769.00	14,309.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,103.00	212.50	FEE SCHEDULE LAB	361,841.75	27,344.75
EKG/ECG	18,405.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,246.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,846.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,256.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,441.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	359,467.00	540.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,214.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,691.04	88.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,746.50	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	4,702.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,115.00	0.00			
			TOTAL ANCILLARY	1,185,200.34	49,347.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,185,200.34	49,347.05

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: 08/29/2018
Run Time: 00:36:54
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,449.19	ADJUSTMENTS	0.00
COVERED CHARGES	33,650.69	CONTRACTUAL ALLOW	14,875.55
NON-COVERD CHARGES	798.50	TOTAL MEDICAID LIAB	18,775.14
		LESS: COB	18,763.14
		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: 08/29/2018
 Run Time: 00:36:54
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	833.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,470.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,052.75	40.50
EKG/ECG	0.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,293.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	522.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,277.25	758.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,650.69	798.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,650.69	798.50

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,084,346.90	ADJUSTMENTS	16,623.69
COVERED CHARGES	1,007,366.57	CONTRACTUAL ALLOW	946,369.04
NON-COVERD CHARGES	76,980.33	TOTAL MEDICAID LIAB	60,997.53
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	60,949.53
		TOTAL NUMBER OF CLAIMS	11

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,046.66	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	194,529.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,063.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,126.00	884.50
EKG/ECG	6,135.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	378.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	88,547.40	11,989.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,508.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,546.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,172.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,337.77	11,048.73
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	163.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,590.40	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	595.04	893.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	468,641.00	52,001.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,734.00	0.00			
			TOTAL ANCILLARY	1,007,366.57	76,980.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,007,366.57	76,980.33

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

FAIRVIEW PARK HOSPITAL
200 INDUSTRIAL BLVD
DUBLIN,GA 31021-2981

PROVIDER NUMBER
000001141A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/16	THROUGH	04/30/17
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: 08/29/2018
 Run Time: 00:54:37
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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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,102,095.43	ADJUSTMENTS	44,179.33
COVERED CHARGES	1,096,128.43	CONTRACTUAL ALLOW	720,695.05
NON-COVERD CHARGES	5,967.00	TOTAL MEDICAID LIAB	375,433.38
		LESS: COB	7,636.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	367,797.04

TOTAL NUMBER OF ADMISSIONS 80

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	156		0	148,980.00		4,014.00
ROUTINE NURSERY	59		0	25,547.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	215		0	174,527.00		4,014.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	15,220.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	15,220.00		0.00
TOTAL ACCOMODATIONS	225		0	189,747.00		4,014.00

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,364.00	0.00	OTHER LAB	5,673.00	0.00
MED/SURG SUPPLY	66,103.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	206,506.53	0.00	EDUCATION & TRAINING	2,261.00	0.00
RADIOLOGY-DIAGNOSTIC	19,466.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,333.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,922.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,599.00	0.00	MRI SERVICES	2,530.00	0.00
IV THERAPY	41,504.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,596.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,351.00	399.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,693.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,226.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,106.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	196,497.20	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	468.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	360.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,531.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,157.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	83.00	1,328.00			
CARDIOLOGY	8,162.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,287.71	226.00			
			TOTAL ANCILLARY	906,381.43	1,953.00
			TOTAL ACCOMODATIONS	189,747.00	4,014.00
			TOTAL CHARGES	1,096,128.43	5,967.00

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

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,314.71	ADJUSTMENTS	0.00
COVERED CHARGES	7,228.71	CONTRACTUAL ALLOW	3,073.96
NON-COVERD CHARGES	86.00	TOTAL MEDICAID LIAB	4,154.75
		LESS: COB	4,154.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	0		0	0.00		0.00
ROUTINE NURSERY	2		0	1,160.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,160.00		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	1,160.00		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
 462 ELMA G MILES PKWY
 HINESVILLE,GA 31313-4000

PROVIDER NUMBER
 000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,598.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	455.71	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,349.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	210.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	480.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	977.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	104.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	86.00			
CARDIOLOGY	895.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,068.71	86.00
			TOTAL ACCOMODATIONS	1,160.00	0.00
			TOTAL CHARGES	7,228.71	86.00

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: 08/29/2018
Run Time: 00:54:38
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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,757,920.54	ADJUSTMENTS	248,380.96
COVERED CHARGES	4,492,973.53	CONTRACTUAL ALLOW	3,614,862.64
NON-COVERD CHARGES	264,947.01	TOTAL MEDICAID LIAB	878,110.89
		LESS: COB	3,608.47
		LESS: COPAYMENT	1,602.42
		REIMBURSEMENT	872,900.00
		ALL OTHER	768,970.25
		FEE SCHEDULE-LAB	92,037.90
		INJECTABLE DRUGS	11,891.85

TOTAL NUMBER OF CLAIMS 2,478

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,600.00	7,202.00	OTHER LAB	51,192.00	0.00
MED/SURG SUPPLY	100,315.60	1,398.82	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	2,128.00
RADIOLOGY-DIAGNOSTIC	233,592.40	3,686.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	759,961.00	74,864.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,407.00	2,673.00	FEE SCHEDULE LAB	1,026,187.11	52,104.34
EKG/ECG	38,442.00	2,533.00	MRI SERVICES	70,595.00	5,527.00
IV THERAPY	169,312.00	46,241.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	157,982.00	6,199.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,975.00	339.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,668.00	10,915.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,711.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,003,529.00	16,005.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,365.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	206,011.30	10,583.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	212.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	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	458.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,838.12	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	189,132.00	12,087.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,257.00	1,022.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,624.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,328.00	2,332.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	134,737.00	6,237.00			
			TOTAL ANCILLARY	4,492,973.53	264,947.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,492,973.53	264,947.01

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

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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,465.77	ADJUSTMENTS	0.00
COVERED CHARGES	34,438.77	CONTRACTUAL ALLOW	23,463.99
NON-COVERD CHARGES	12,027.00	TOTAL MEDICAID LIAB	10,974.78
		LESS: COB	10,971.78
		LESS: COPAYMENT	3.00
		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

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	604.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	791.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,321.00	189.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,774.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,219.00	228.00
EKG/ECG	447.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,259.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,431.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	279.50	401.00	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	8,114.00	120.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,798.00	487.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,397.00	2,397.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,438.77	12,027.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,438.77	12,027.00

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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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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	259,984.00	ADJUSTMENTS	241.00
COVERED CHARGES	251,330.00	CONTRACTUAL ALLOW	238,130.00
NON-COVERD CHARGES	8,654.00	TOTAL MEDICAID LIAB	13,200.00
		LESS: COB	33.59
		LESS: COPAYMENT	370.74
		REIMBURSEMENT	12,795.67
		TOTAL NUMBER OF CLAIMS	264

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,242.00	764.00	OTHER LAB	1,790.00	0.00
MED/SURG SUPPLY	3,098.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,849.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,368.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54,118.00	6,778.00
EKG/ECG	894.00	0.00	MRI SERVICES	2,598.00	0.00
IV THERAPY	6,354.00	435.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	393.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,211.00	600.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,878.00	77.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,536.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	251,330.00	8,654.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	251,330.00	8,654.00

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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,522.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,410.00	CONTRACTUAL ALLOW	906.99
NON-COVERD CHARGES	112.00	TOTAL MEDICAID LIAB	503.01
		LESS: COB	500.01
		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

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 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	496.00	112.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	914.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,410.00	112.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,410.00	112.00

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

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 12/01/16 THROUGH 11/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	194,138.12	ADJUSTMENTS	24,761.05
COVERED CHARGES	180,100.12	CONTRACTUAL ALLOW	155,318.07
NON-COVERD CHARGES	14,038.00	TOTAL MEDICAID LIAB	24,782.05
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	24,761.05

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 12/01/16 THROUGH 11/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,321.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,243.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	133.00
RADIOLOGY-DIAGNOSTIC	2,217.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,879.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	357.00	FEE SCHEDULE LAB	9,173.00	0.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,182.00	8,128.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	83,241.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,736.75	1,053.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,276.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,952.00	0.00	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	4,940.00	4,247.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,075.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,707.00	120.00			
			TOTAL ANCILLARY	180,100.12	14,038.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	180,100.12	14,038.00

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: 08/29/2018
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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	12/01/16	THROUGH	11/30/17
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: 08/29/2018
 Run Time: 00:53:00
 Page: 1

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	121,756.75	ADJUSTMENTS	0.00
COVERED CHARGES	120,007.75	CONTRACTUAL ALLOW	56,296.05
NON-COVERD CHARGES	1,749.00	TOTAL MEDICAID LIAB	63,711.70
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	63,711.70
		TOTAL NUMBER OF ADMISSIONS	10

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	49		0	21,315.00		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	49		0	21,315.00		825.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	49		0	21,315.00		825.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
 116 W THIGPEN AVENUE
 LAKELAND,GA 31635-1006

PROVIDER NUMBER
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,690.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,351.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,713.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,278.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,154.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	326.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	744.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,092.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,317.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,841.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	610.50	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	269.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	564.00	924.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,742.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	98,692.75	924.00
			TOTAL ACCOMODATIONS	21,315.00	825.00
			TOTAL CHARGES	120,007.75	1,749.00

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF 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 10/01/16 THROUGH 09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	644,465.64	ADJUSTMENTS	26,877.60
COVERED CHARGES	609,006.95	CONTRACTUAL ALLOW	406,364.05
NON-COVERD CHARGES	35,458.69	TOTAL MEDICAID LIAB	202,642.90
		LESS: COB	0.00
		LESS: COPAYMENT	417.00
		REIMBURSEMENT	202,225.90
		ALL OTHER	173,611.39
		FEE SCHEDULE-LAB	26,995.30
		INJECTABLE DRUGS	1,619.21

TOTAL NUMBER OF CLAIMS 815

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,033.95	8.84	OTHER LAB	4,160.00	0.00
MED/SURG SUPPLY	6,987.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,097.00	2,417.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,313.00	22,418.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,157.00	955.00	FEE SCHEDULE LAB	178,565.95	5,598.00
EKG/ECG	10,788.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,650.00	636.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	165,311.00	360.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,882.80	921.35
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	595.50	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	5,448.00	497.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,128.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,371.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	77,076.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,037.50	1,052.00			
			TOTAL ANCILLARY	609,006.95	35,458.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	609,006.95	35,458.69

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,212.70	ADJUSTMENTS	0.00
COVERED CHARGES	990.70	CONTRACTUAL ALLOW	-1,093.91
NON-COVERD CHARGES	2,222.00	TOTAL MEDICAID LIAB	2,084.61
		LESS: COB	2,084.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,213.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	345.00	9.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	31.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	990.70	2,222.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	990.70	2,222.00

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

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

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HOSPITAL AUTHORITY OF 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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,889.50	ADJUSTMENTS	94.00
COVERED CHARGES	44,600.64	CONTRACTUAL ALLOW	40,350.64
NON-COVERD CHARGES	288.86	TOTAL MEDICAID LIAB	4,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	4,121.00
		TOTAL NUMBER OF CLAIMS	85

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,389.29	0.00	OTHER LAB	0.00	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	1,802.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,213.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,183.00	62.00
EKG/ECG	558.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,131.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,419.00	179.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,679.35	47.86
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	44,600.64	288.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	44,600.64	288.86

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	234.00	ADJUSTMENTS	0.00
COVERED CHARGES	234.00	CONTRACTUAL ALLOW	156.75
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	77.25
		LESS: COB	77.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,
 116 W THIGPEN AVENUE
 LAKELAND,GA 31635-1006

PROVIDER NUMBER
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	234.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	234.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	234.00	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

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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	851,601.54	ADJUSTMENTS	59,666.45
COVERED CHARGES	851,601.54	CONTRACTUAL ALLOW	515,049.96
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	336,551.58
		LESS: COB	2,295.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	334,255.83

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	83		0	48,140.00		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	83		0	48,140.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	61		0	59,353.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	61		0	59,353.00		0.00
TOTAL ACCOMODATIONS	144		0	107,493.00		0.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	209,384.88	0.00	OTHER LAB	2,288.00	0.00
MED/SURG SUPPLY	108,416.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,053.51	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,906.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,750.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,574.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,454.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,012.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,222.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,259.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,956.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	71.00	0.00
EMERGENCY ROOM	48,636.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,694.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	829.92	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,431.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	402.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	756.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93,305.21	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,002.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,006.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,709.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,991.00	0.00			
			TOTAL ANCILLARY	744,108.54	0.00
			TOTAL ACCOMODATIONS	107,493.00	0.00
			TOTAL CHARGES	851,601.54	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

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 01/01/17 THROUGH 12/31/17
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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,933,779.07	ADJUSTMENTS	117,577.94
COVERED CHARGES	3,779,416.14	CONTRACTUAL ALLOW	2,995,956.72
NON-COVERD CHARGES	154,362.93	TOTAL MEDICAID LIAB	783,459.42
		LESS: COB	14,770.90
		LESS: COPAYMENT	1,260.00
		REIMBURSEMENT	767,428.52
		ALL OTHER	703,236.14
		FEE SCHEDULE-LAB	59,859.11
		INJECTABLE DRUGS	4,333.27
		TOTAL NUMBER OF CLAIMS	1,779

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182,988.94	9.06	OTHER LAB	112,967.00	0.00
MED/SURG SUPPLY	238,707.13	9,330.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	198,989.00	3,203.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	603,361.00	48,723.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	390,947.26	9,314.98
EKG/ECG	71,403.00	3,406.00	MRI SERVICES	0.00	0.00
IV THERAPY	205,675.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	299,975.00	36,881.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,264.00	4,262.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,913.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,140,060.00	1,302.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	65,292.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151,849.49	27,347.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	547.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	729.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,536.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,081.32	2,469.86
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,562.00	593.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,776.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,709.00	1,709.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,896.00	0.00			
			TOTAL ANCILLARY	3,779,416.14	154,362.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,779,416.14	154,362.93

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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,920.20	ADJUSTMENTS	0.00
COVERED CHARGES	30,572.24	CONTRACTUAL ALLOW	15,854.32
NON-COVERD CHARGES	2,347.96	TOTAL MEDICAID LIAB	14,717.92
		LESS: COB	14,705.92
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

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 01/01/17 THROUGH 12/31/17
 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	490.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,095.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,090.00	273.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,179.00	1,776.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,610.97	40.00
EKG/ECG	786.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,797.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,231.00	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	1,143.14	258.96
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	940.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,572.24	2,347.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,572.24	2,347.96

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

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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	137,604.37	ADJUSTMENTS	0.00
COVERED CHARGES	136,167.15	CONTRACTUAL ALLOW	128,671.19
NON-COVERD CHARGES	1,437.22	TOTAL MEDICAID LIAB	7,495.96
		LESS: COB	0.00
		LESS: COPAYMENT	249.00
		REIMBURSEMENT	7,246.96
		TOTAL NUMBER OF CLAIMS	134

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 01/01/17 THROUGH 12/31/17
 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	3,507.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,042.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,282.00	594.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,872.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,952.15	120.52
EKG/ECG	1,834.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,823.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	630.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	79,887.00	198.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,744.36	524.70
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	593.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	136,167.15	1,437.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	136,167.15	1,437.22

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,804.02	ADJUSTMENTS	0.00
COVERED CHARGES	18,804.02	CONTRACTUAL ALLOW	13,258.79
NON-COVERD CHARGES	0.00	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

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	01/01/17	THROUGH	12/31/17
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	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	417.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,776.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	412.00	0.00
EKG/ECG	262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	394.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,669.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,874.02	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	18,804.02	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,804.02	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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
 Run Time: 00:12:31
 Page: 1

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,817,466.92	ADJUSTMENTS	2,149,238.05
COVERED CHARGES	50,236,467.59	CONTRACTUAL ALLOW	33,950,560.17
NON-COVERD CHARGES	1,580,999.33	TOTAL MEDICAID LIAB	16,285,907.42
		LESS: COB	134,224.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,151,683.09

TOTAL NUMBER OF ADMISSIONS 1,484

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,118		0	4,505,751.92		205,848.00
ROUTINE NURSERY	1,039		0	718,773.50		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,157		0	5,224,525.42		205,848.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,484		0	2,514,006.00		0.00
NICU	223		0	383,460.00		0.00
PED ICU	24		0	40,851.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,731		0	2,938,317.00		0.00
TOTAL ACCOMODATIONS	9,888		0	8,162,842.42		205,848.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,301,056.62	6,362.55	OTHER LAB	206,358.82	573.00
MED/SURG SUPPLY	3,420,178.00	4,440.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,430,516.27	13,235.77	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,031,710.99	428.04	OTHER THERAPEUTIC SVC	0.00	9,445.00
CT SCAN	1,629,961.29	556,170.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	373,359.57	1,447.32	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	168,724.59	155.85	MRI SERVICES	772,161.22	0.00
IV THERAPY	215,349.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,612,862.33	35,697.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,008,567.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,524,512.77	136.53	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	254,528.53	0.00	AMBULANCE	0.00	35,092.88
GI SERVICES	526,500.00	21,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,809,279.36	637.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	492,715.57	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	145,183.62	0.00	INJECTABLE DRUGS	8,850,919.26	5,773.60
RADIOLOGY THERAPEUTIC	348,367.46	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	210,883.63	906.64	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	120,393.14	563.33	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	209,125.32	9,971.68	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,476.43	12,363.10	TRAUMA RESPONSE	0.00	26,480.75
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,569,390.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	406,371.89	734.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,090,424.19	630,688.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	129,097.45	777.72			
AUDIOLOGY	79,895.00	0.00			
CARDIOLOGY	1,006,424.46	1,570.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	63,061.60	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,269.15	0.00			
			TOTAL ANCILLARY	42,073,625.17	1,375,151.33
			TOTAL ACCOMODATIONS	8,162,842.42	205,848.00
			TOTAL CHARGES	50,236,467.59	1,580,999.33

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	270,974.34	ADJUSTMENTS	0.00
COVERED CHARGES	264,954.68	CONTRACTUAL ALLOW	92,895.32
NON-COVERD CHARGES	6,019.66	TOTAL MEDICAID LIAB	172,059.36
		LESS: COB	172,059.36
		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	38		0	24,092.00		1,464.00
ROUTINE NURSERY	63		0	43,950.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	101		0	68,042.00		1,464.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	13		0	21,840.00		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	15		0	25,200.00		0.00
TOTAL ACCOMODATIONS	116		0	93,242.00		1,464.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,375.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24,136.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,559.98	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,698.41	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,171.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	985.92	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	155.85	0.00	MRI SERVICES	2,978.13	0.00
IV THERAPY	1,836.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,838.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,614.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,408.92	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	4,555.66
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,209.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,988.46	0.00	INJECTABLE DRUGS	43,640.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,316.64	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	209.66	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,857.83	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,141.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,102.00	0.00			
CARDIOLOGY	6,332.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,156.50	0.00			
			TOTAL ANCILLARY	171,712.68	4,555.66
			TOTAL ACCOMODATIONS	93,242.00	1,464.00
			TOTAL CHARGES	264,954.68	6,019.66

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

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

Run Date: 08/29/2018
Run Time: 00:12:44
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,014,593.41	ADJUSTMENTS	116,934.35
COVERED CHARGES	17,054,123.66	CONTRACTUAL ALLOW	11,158,980.11
NON-COVERD CHARGES	2,960,469.75	TOTAL MEDICAID LIAB	5,895,143.55
		LESS: COB	10,492.31
		LESS: COPAYMENT	21,977.91
		REIMBURSEMENT	5,862,673.33
		ALL OTHER	5,298,851.92
		FEE SCHEDULE-LAB	271,287.27
		INJECTABLE DRUGS	292,534.14
		TOTAL NUMBER OF CLAIMS	13,372

MIDTOWN MEDICAL CENTER
 710 CENTER STREET
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217,599.59	627.75	OTHER LAB	66,177.74	0.00
MED/SURG SUPPLY	217,376.00	602.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	660,774.95	58,700.94	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,542,461.83	206,740.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,294.40	7,732.84	FEE SCHEDULE LAB	2,361,195.30	93,451.51
EKG/ECG	144,096.17	0.00	MRI SERVICES	336,247.21	42,049.09
IV THERAPY	1,638,376.86	11,029.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	789,315.16	275,100.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,046.52	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	149,222.14	97,374.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	101,208.84	1,398.00	AMBULANCE	0.00	0.00
GI SERVICES	427,666.66	61,333.34	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,209,710.41	21,845.85	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	299,567.58	2,265.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,130,906.91	938,032.98
RADIOLOGY THERAPEUTIC	840,904.07	760,336.47	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,925.90	3,119.16	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	345.00	5,421.98	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,091.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	87.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	645,477.90	32,746.39	TRAUMA RESPONSE	0.00	6,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	56,067.60	3,621.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	483,031.53	55,757.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	166,816.50	143,383.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	62,588.15	86,071.05			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	79,611.60	38,696.80			
AMBULATORY SURGERY	7,864.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	205,234.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	179,925.44	2,906.35			
			TOTAL ANCILLARY	17,054,123.66	2,959,835.75
			TOTAL ACCOMODATIONS	0.00	634.00
			TOTAL CHARGES	17,054,123.66	2,960,469.75

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

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

Run Date: 08/29/2018
Run Time: 00:13:23
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	235,336.44	ADJUSTMENTS	0.00
COVERED CHARGES	174,604.40	CONTRACTUAL ALLOW	80,822.07
NON-COVERD CHARGES	60,732.04	TOTAL MEDICAID LIAB	93,782.33
		LESS: COB	93,609.85
		LESS: COPAYMENT	172.48
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 93

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

MIDTOWN MEDICAL CENTER
 710 CENTER STREET
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,751.53	48.60	OTHER LAB	2,834.56	0.00
MED/SURG SUPPLY	2,780.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,215.61	1,890.00	OTHER THERAPEUTIC SVC	0.00	1,370.00
CT SCAN	2,461.00	4,802.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,342.36	477.47
EKG/ECG	155.85	0.00	MRI SERVICES	0.00	1,691.00
IV THERAPY	5,496.00	434.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,776.86	13,745.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	412.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,533.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,000.00	3,000.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,357.05	828.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,554.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,016.91	25,245.29
RADIOLOGY THERAPEUTIC	1,108.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	357.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,580.80	1,248.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,475.05	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,173.12	4,718.76			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,331.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	560.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,390.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,857.84	315.00			
			TOTAL ANCILLARY	174,604.40	60,732.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	174,604.40	60,732.04

Report : CLM-0808-0
Process : CLMJ0800
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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MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	940,653.73	ADJUSTMENTS	376.58
COVERED CHARGES	920,639.68	CONTRACTUAL ALLOW	869,454.58
NON-COVERD CHARGES	20,014.05	TOTAL MEDICAID LIAB	51,185.10
		LESS: COB	86.87
		LESS: COPAYMENT	1,411.48
		REIMBURSEMENT	49,686.75
		TOTAL NUMBER OF CLAIMS	915

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,887.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,452.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,433.52	2,160.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,265.20	5,297.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	276.64	FEE SCHEDULE LAB	167,849.77	5,287.24
EKG/ECG	10,925.14	0.00	MRI SERVICES	13,450.51	0.00
IV THERAPY	59,002.00	231.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,211.72	368.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,053.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,532.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,781.34	188.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	510,365.40	191.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,434.18	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,499.15	1,564.95
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	134.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,095.66	2,092.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,327.25	2,223.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,073.94	0.00			
			TOTAL ANCILLARY	920,639.68	20,014.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	920,639.68	20,014.05

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

MIDTOWN MEDICAL CENTER
710 CENTER STREET
COLUMBUS,GA 31902-1527

PROVIDER NUMBER
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,561.48	ADJUSTMENTS	0.00
COVERED CHARGES	25,112.42	CONTRACTUAL ALLOW	16,251.11
NON-COVERD CHARGES	449.06	TOTAL MEDICAID LIAB	8,861.31
		LESS: COB	8,846.31
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

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

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

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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	194.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,746.20	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	4,891.77	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,608.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,278.70	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	418.55	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	927.00	449.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,112.42	449.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,112.42	449.06

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,520,784.27	ADJUSTMENTS	23,416.12
COVERED CHARGES	3,912,333.24	CONTRACTUAL ALLOW	3,080,528.48
NON-COVERD CHARGES	608,451.03	TOTAL MEDICAID LIAB	831,804.76
		LESS: COB	474.69
		LESS: COPAYMENT	1,344.00
		REIMBURSEMENT	829,986.07
		TOTAL NUMBER OF CLAIMS	142

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,050.41	1,258.95	OTHER LAB	410.00	0.00
MED/SURG SUPPLY	169,362.85	1,172.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,180.48	9,135.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,962.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,570.43	FEE SCHEDULE LAB	45,040.15	683.69
EKG/ECG	2,088.41	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	225,132.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	644,778.34	73,168.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,882.24	412.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,513.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,000.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,645.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	145,757.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,231,561.22	187,165.95
RADIOLOGY THERAPEUTIC	504,300.49	289,222.69	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,224.00	100.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	572,426.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,155.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,639.00	10,003.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	43,991.90	4,211.04			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	121,683.98	28,653.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,547.83	0.00			
			TOTAL ANCILLARY	3,912,333.24	607,757.03
			TOTAL ACCOMODATIONS	0.00	694.00
			TOTAL CHARGES	3,912,333.24	608,451.03

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

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	175,418.86	ADJUSTMENTS	0.00
COVERED CHARGES	159,334.29	CONTRACTUAL ALLOW	29,404.68
NON-COVERD CHARGES	16,084.57	TOTAL MEDICAID LIAB	129,929.61
		LESS: COB	129,893.61
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	792.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,941.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	4,292.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,878.54	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,722.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	9,543.72	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	491.84	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,189.18	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,834.33	2,248.85
RADIOLOGY THERAPEUTIC	6,312.00	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	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,012.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	112,161.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	159,334.29	16,084.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	159,334.29	16,084.57

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	154,168,467.38	ADJUSTMENTS	4,522,271.31
COVERED CHARGES	149,937,217.21	CONTRACTUAL ALLOW	112,066,592.07
NON-COVERD CHARGES	4,231,250.17	TOTAL MEDICAID LIAB	37,870,625.14
		LESS: COB	352,941.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	37,517,683.87

TOTAL NUMBER OF ADMISSIONS 2,658

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,863		3	10,665,672.00		920,014.00
ROUTINE NURSERY	2,196		0	7,490,353.00		400,420.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15,059		3	18,156,025.00		1,320,434.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4,074		0	11,321,921.00		107,950.00
NICU	152		0	894,520.00		0.00
PED ICU	722		0	2,200,275.00		92,075.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,948		0	14,416,716.00		200,025.00
TOTAL ACCOMODATIONS	20,007		3	32,572,741.00		1,520,459.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,436,991.78	349,167.84	OTHER LAB	969,566.00	4,376.00
MED/SURG SUPPLY	4,401,794.00	113,438.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,537,410.50	101,819.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,569,932.00	4,932.00	OTHER THERAPEUTIC SVC	0.00	14,693.00
CT SCAN	6,173,400.00	145,721.00	SPECIAL CHARGES	37,606.00	0.00
PHYSICAL THERAPY	739,693.00	4,246.04	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	503,290.00	185.00	MRI SERVICES	2,436,777.00	11,915.00
IV THERAPY	735,475.00	1,536.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,262,474.25	47,598.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,321,065.00	6,310.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,475,653.00	133,660.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,653,183.00	6,237.00	AMBULANCE	0.00	0.00
GI SERVICES	11,616.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,047,288.00	2,572.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,182,713.00	1,421.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	251,628.00	365.00	INJECTABLE DRUGS	9,824,753.47	518,949.27
RADIOLOGY THERAPEUTIC	57,236.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	259,510.73	995.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	368,348.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,241,592.00	1,010,219.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	725.00	44,837.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	64,253.00	0.00	IMPL DEV CHARGE PATIENTS	6,035,533.48	1,886.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	338,192.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,560,607.00	50,357.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	539,785.00	28,343.00			
AUDIOLOGY	0.00	28,644.00			
CARDIOLOGY	3,179,593.00	2,837.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	135,134.00	3,786.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,011,658.00	69,746.00			
			TOTAL ANCILLARY	117,364,476.21	2,710,791.17
			TOTAL ACCOMODATIONS	32,572,741.00	1,520,459.00
			TOTAL CHARGES	149,937,217.21	4,231,250.17

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,349,249.84	ADJUSTMENTS	0.00
COVERED CHARGES	1,321,271.84	CONTRACTUAL ALLOW	785,919.96
NON-COVERD CHARGES	27,978.00	TOTAL MEDICAID LIAB	535,351.88
		LESS: COB	535,351.88
		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	83		0	67,550.00		10,960.00
ROUTINE NURSERY	64		0	210,244.00		16,646.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	147		0	277,794.00		27,606.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	43		0	121,025.00		0.00
NICU	0		0	0.00		0.00
PED ICU	9		0	28,575.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	52		0	149,600.00		0.00
TOTAL ACCOMODATIONS	199		0	427,394.00		27,606.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189,538.72	0.00	OTHER LAB	2,795.00	0.00
MED/SURG SUPPLY	36,535.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	102,287.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,112.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,813.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,597.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,590.00	0.00	MRI SERVICES	20,972.00	0.00
IV THERAPY	6,924.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,335.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,184.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	128,359.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,177.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,571.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,968.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,948.00	0.00	INJECTABLE DRUGS	60,472.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,051.06	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,887.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,792.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,732.00	0.00	IMPL DEV CHARGE PATIENTS	51,421.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,935.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,432.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	372.00			
CARDIOLOGY	28,149.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,466.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,809.00	0.00			
			TOTAL ANCILLARY	893,877.84	372.00
			TOTAL ACCOMODATIONS	427,394.00	27,606.00
			TOTAL CHARGES	1,321,271.84	27,978.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,443,950.06	ADJUSTMENTS	1,307,687.80
COVERED CHARGES	45,658,475.91	CONTRACTUAL ALLOW	36,083,154.51
NON-COVERD CHARGES	5,785,474.15	TOTAL MEDICAID LIAB	9,575,321.40
		LESS: COB	40,461.71
		LESS: COPAYMENT	26,291.04
		REIMBURSEMENT	9,508,568.65
		ALL OTHER	7,799,384.75
		FEE SCHEDULE-LAB	922,597.13
		INJECTABLE DRUGS	786,586.77

TOTAL NUMBER OF CLAIMS 22,639

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

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

Run Date: 08/29/2018
 Run Time: 00:31:03
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,130,199.93	36,398.95	OTHER LAB	373,807.00	560.00
MED/SURG SUPPLY	740,483.79	52,942.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,955,930.00	208,467.00	OTHER THERAPEUTIC SVC	0.00	6,102.80
CT SCAN	3,576,195.00	627,904.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,804.00	20,153.42	FEE SCHEDULE LAB	9,526,819.78	235,067.00
EKG/ECG	347,536.00	19,425.00	MRI SERVICES	96,762.00	112,404.00
IV THERAPY	2,107,721.00	170,861.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,783,288.85	1,288,054.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	164,579.00	36,358.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	225,474.00	81,201.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,213,453.00	1,255.00	AMBULANCE	0.00	0.00
GI SERVICES	63,428.00	1,047.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,850,759.50	25,844.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,450,425.00	1,421.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,066,516.06	717,654.47
RADIOLOGY THERAPEUTIC	211,691.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,974.00	7,775.42	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	37,140.00	10,146.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	63,710.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,962,089.00	140,359.93	TRAUMA RESPONSE	0.00	9,160.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	326,888.00	1,116,064.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	427,813.00	60,464.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	466,694.00	3,508.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	578,794.00	191,599.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	449,332.00	327,077.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	133,396.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,307,483.00	212,490.00			
			TOTAL ANCILLARY	45,658,475.91	5,785,474.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	45,658,475.91	5,785,474.15

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	880,590.62	ADJUSTMENTS	0.00
COVERED CHARGES	646,066.24	CONTRACTUAL ALLOW	303,193.78
NON-COVERD CHARGES	234,524.38	TOTAL MEDICAID LIAB	342,872.46
		LESS: COB	342,647.26
		LESS: COPAYMENT	225.20
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 318

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 10/01/16 THROUGH 09/30/17
 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	25,635.86	8,651.40	OTHER LAB	1,799.00	0.00
MED/SURG SUPPLY	9,601.00	155.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,459.00	1,648.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,613.00	46,203.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83,675.00	2,703.00
EKG/ECG	3,301.00	0.00	MRI SERVICES	0.00	7,014.00
IV THERAPY	30,283.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,287.12	41,551.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,630.00	1,256.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,381.00	901.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,214.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,047.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	79,629.00	203.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,144.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	77,911.26	95,187.10
RADIOLOGY THERAPEUTIC	7,839.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	603.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	45,337.00	5,307.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,197.00	585.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,061.00	2,654.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,650.00	865.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,416.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,353.00	19,640.00			
			TOTAL ANCILLARY	646,066.24	234,524.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	646,066.24	234,524.38

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

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

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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	741,751.95	ADJUSTMENTS	538.40
COVERED CHARGES	720,282.49	CONTRACTUAL ALLOW	692,592.19
NON-COVERD CHARGES	21,469.46	TOTAL MEDICAID LIAB	27,690.30
		LESS: COB	0.00
		LESS: COPAYMENT	971.16
		REIMBURSEMENT	26,719.14
		TOTAL NUMBER OF CLAIMS	495

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)
 777 HEMLOCK ST
 MACON,GA 31201-2102

PROVIDER NUMBER
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,994.54	127.34	OTHER LAB	2,330.00	0.00
MED/SURG SUPPLY	186.00	274.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,876.00	6,611.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,382.00	8,543.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	162,997.00	2,693.00
EKG/ECG	8,325.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	43,226.00	268.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,153.00	1,085.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,094.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	360,585.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,886.95	1,441.12
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	1,494.00	427.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	732.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,969.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,052.00	0.00			
			TOTAL ANCILLARY	720,282.49	21,469.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	720,282.49	21,469.46

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,642.75	ADJUSTMENTS	0.00
COVERED CHARGES	27,153.55	CONTRACTUAL ALLOW	11,088.31
NON-COVERD CHARGES	489.20	TOTAL MEDICAID LIAB	16,065.24
		LESS: COB	16,044.24
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,829.35	489.20	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	2,394.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,102.00	0.00
EKG/ECG	555.00	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	12,592.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	321.20	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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,153.55	489.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,153.55	489.20

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,368,448.47	ADJUSTMENTS	193,014.20
COVERED CHARGES	8,074,240.39	CONTRACTUAL ALLOW	6,858,028.82
NON-COVERD CHARGES	1,294,208.08	TOTAL MEDICAID LIAB	1,216,211.57
		LESS: COB	14,555.89
		LESS: COPAYMENT	525.00
		REIMBURSEMENT	1,201,130.68

TOTAL NUMBER OF CLAIMS 201

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

MEDICAL CENTER, NAVICENT HEALTH (THE) PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/16 THROUGH 09/30/17
 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	281,178.28	4,957.02	OTHER LAB	31,584.00	0.00
MED/SURG SUPPLY	403,519.00	215,289.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,129.00	70,717.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	76,605.00	36,541.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	7,185.22	FEE SCHEDULE LAB	204,835.00	3,965.00
EKG/ECG	18,685.00	3,145.00	MRI SERVICES	16,329.00	13,570.00
IV THERAPY	85,070.00	27,989.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,046,104.50	149,558.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,288.00	10,550.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94,581.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,047.00	1,047.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,009.60	2,630.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	81,327.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,980,598.01	87,534.86
RADIOLOGY THERAPEUTIC	45,699.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,516.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	429.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,376.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,495.00	2,197.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,032,997.00	432,689.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,375.00	1,501.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,257.00	877.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,698.00	20,676.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	286,969.00	45,391.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	822.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,185,039.00	148,877.00			
			TOTAL ANCILLARY	8,074,240.39	1,294,208.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,074,240.39	1,294,208.08

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

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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL
 610 SPARTA ROAD
 SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER 000001218A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	231,844.92	ADJUSTMENTS	27,591.42
COVERED CHARGES	228,200.92	CONTRACTUAL ALLOW	98,969.35
NON-COVERD CHARGES	3,644.00	TOTAL MEDICAID LIAB	129,231.57
		LESS: COB	3,877.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	125,353.63

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	55		0	17,600.00		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	55		0	17,600.00		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	55		0	17,600.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL
 610 SPARTA ROAD
 SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER
 000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,987.49	0.00	OTHER LAB	2,906.00	0.00
MED/SURG SUPPLY	14,411.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,568.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,436.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,276.00	3,644.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	977.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,106.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	476.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,624.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,742.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	972.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,989.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	74.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	338.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	136.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,308.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,724.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,716.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,834.00	0.00			
			TOTAL ANCILLARY	210,600.92	3,644.00
			TOTAL ACCOMODATIONS	17,600.00	0.00
			TOTAL CHARGES	228,200.92	3,644.00

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

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	09/01/16	THROUGH	08/31/17
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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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,266,835.99	ADJUSTMENTS	59,611.11
COVERED CHARGES	1,227,149.81	CONTRACTUAL ALLOW	887,119.74
NON-COVERD CHARGES	39,686.18	TOTAL MEDICAID LIAB	340,030.07
		LESS: COB	913.57
		LESS: COPAYMENT	1,119.00
		REIMBURSEMENT	337,997.50
		ALL OTHER	296,950.43
		FEE SCHEDULE-LAB	38,627.09
		INJECTABLE DRUGS	2,419.98
		TOTAL NUMBER OF CLAIMS	1,159

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,820.17	399.70	OTHER LAB	9,340.00	0.00
MED/SURG SUPPLY	32,223.95	482.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,227.00	115.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,656.00	14,376.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,479.00	1,472.00	FEE SCHEDULE LAB	218,165.00	3,577.00
EKG/ECG	15,916.00	162.00	MRI SERVICES	16,345.00	884.00
IV THERAPY	53,915.68	556.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	76,197.02	3,653.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,701.00	2,134.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,391.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	317,727.85	1,735.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,563.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,045.14	3,357.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	228.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	272.00	192.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,014.00	809.90	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	954.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,059.00	959.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,246.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,306.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,384.00	3,846.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	62,100.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,102.00	747.00			
			TOTAL ANCILLARY	1,227,149.81	39,686.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,227,149.81	39,686.18

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,879.50	ADJUSTMENTS	0.00
COVERED CHARGES	8,242.50	CONTRACTUAL ALLOW	3,206.21
NON-COVERD CHARGES	1,637.00	TOTAL MEDICAID LIAB	5,036.29
		LESS: COB	4,997.29
		LESS: COPAYMENT	39.00
		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

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125.00	0.00	OTHER LAB	269.00	0.00
MED/SURG SUPPLY	310.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	230.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,065.00	99.00
EKG/ECG	81.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	88.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	333.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22.50	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	1,538.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,719.00	0.00			
			TOTAL ANCILLARY	8,242.50	1,637.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,242.50	1,637.00

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: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,946.53	ADJUSTMENTS	479.46
COVERED CHARGES	114,274.35	CONTRACTUAL ALLOW	103,589.81
NON-COVERD CHARGES	3,672.18	TOTAL MEDICAID LIAB	10,684.54
		LESS: COB	0.00
		LESS: COPAYMENT	421.82
		REIMBURSEMENT	10,262.72
		TOTAL NUMBER OF CLAIMS	191

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,051.80	194.08	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	864.00	144.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,948.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,611.00	632.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	282.00	FEE SCHEDULE LAB	14,110.00	170.00
EKG/ECG	486.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,033.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,121.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,614.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,435.55	1,981.10
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	0.00	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	0.00	0.00			
			TOTAL ANCILLARY	114,274.35	3,672.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	114,274.35	3,672.18

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	284.00	ADJUSTMENTS	0.00
COVERED CHARGES	284.00	CONTRACTUAL ALLOW	150.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	134.00
		LESS: COB	134.00
		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

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 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	82.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	284.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	284.00	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

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	09/01/16	THROUGH	08/31/17
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

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	09/01/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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

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

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

COOK MEDICAL CENTER
 706 N PARRISH AVE
 ADEL, GA 31620-1511

PROVIDER NUMBER 000001251A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	375,706.02	ADJUSTMENTS	0.00
COVERED CHARGES	335,866.02	CONTRACTUAL ALLOW	227,662.84
NON-COVERD CHARGES	39,840.00	TOTAL MEDICAID LIAB	108,203.18
		LESS: COB	212.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	107,990.98

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	112		0	100,800.00		39,840.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	112		0	100,800.00		39,840.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	112		0	100,800.00		39,840.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,000.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,003.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,743.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,309.17	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,197.94	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,367.47	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,209.83	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,348.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,006.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,667.42	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	87,408.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,128.85	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	50.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,404.47	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,217.32	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,001.97	0.00			
			TOTAL ANCILLARY	235,066.02	0.00
			TOTAL ACCOMODATIONS	100,800.00	39,840.00
			TOTAL CHARGES	335,866.02	39,840.00

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,536.69	ADJUSTMENTS	0.00
COVERED CHARGES	20,965.10	CONTRACTUAL ALLOW	9,195.76
NON-COVERD CHARGES	571.59	TOTAL MEDICAID LIAB	11,769.34
		LESS: COB	11,769.34
		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	5		0	4,500.00		500.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	4,500.00		500.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	4,500.00		500.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	770.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,770.64	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.43	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,630.11	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	419.29	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	249.09	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	71.59
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	731.91	0.00	FREE STANDING CLINIC	0.00	0.00
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	6,804.80	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,465.10	71.59
			TOTAL ACCOMODATIONS	4,500.00	500.00
			TOTAL CHARGES	20,965.10	571.59

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,306,009.04	ADJUSTMENTS	51,345.81
COVERED CHARGES	1,236,305.72	CONTRACTUAL ALLOW	1,009,358.08
NON-COVERD CHARGES	69,703.32	TOTAL MEDICAID LIAB	226,947.64
		LESS: COB	89.15
		LESS: COPAYMENT	654.00
		REIMBURSEMENT	226,204.49
		ALL OTHER	190,914.33
		FEE SCHEDULE-LAB	35,096.83
		INJECTABLE DRUGS	193.33
		TOTAL NUMBER OF CLAIMS	1,137

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,010.25	9,711.33	OTHER LAB	74,584.99	0.00
MED/SURG SUPPLY	14,127.78	502.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	96,041.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	216,760.09	13,896.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,808.35	4,172.54	FEE SCHEDULE LAB	396,473.97	19,720.24
EKG/ECG	12,013.53	476.86	MRI SERVICES	0.00	0.00
IV THERAPY	28,176.89	1,335.29	PROFESSIONAL FEES	0.00	3,666.39
OPERATING ROOM	2,539.12	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,182.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,119.51	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,600.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	249,360.15	2,314.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,043.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,023.25	1,192.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	838.64	838.64	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,392.85	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	183.64	287.87	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,057.14	3,722.41			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	483.48	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,835.45	3,671.34			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,390.07	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	9,652.56	1,801.20			
			TOTAL ANCILLARY	1,236,305.72	69,703.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,236,305.72	69,703.32

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,801.19	ADJUSTMENTS	0.00
COVERED CHARGES	20,936.30	CONTRACTUAL ALLOW	9,247.74
NON-COVERD CHARGES	4,864.89	TOTAL MEDICAID LIAB	11,688.56
		LESS: COB	11,682.56
		LESS: COPAYMENT	6.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	875.34	185.77	OTHER LAB	4,011.84	0.00
MED/SURG SUPPLY	245.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	925.66	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	7,927.62	202.84
EKG/ECG	975.04	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	63.24	0.00	PROFESSIONAL FEES	0.00	3,596.95
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416.67	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,423.15	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	72.50	9.59
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	869.74			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,936.30	4,864.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,936.30	4,864.89

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,667.86	ADJUSTMENTS	479.46
COVERED CHARGES	67,395.51	CONTRACTUAL ALLOW	60,132.85
NON-COVERD CHARGES	1,272.35	TOTAL MEDICAID LIAB	7,262.66
		LESS: COB	0.00
		LESS: COPAYMENT	291.00
		REIMBURSEMENT	6,971.66
		TOTAL NUMBER OF CLAIMS	130

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,005.57	871.49	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	650.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,098.14	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,410.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,463.56	210.16
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,957.49	0.00	PROFESSIONAL FEES	0.00	34.20
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,788.62	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	151.48	156.50
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	869.74	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	67,395.51	1,272.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,395.51	1,272.35

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,555.01	ADJUSTMENTS	0.00
COVERED CHARGES	5,347.79	CONTRACTUAL ALLOW	1,072.25
NON-COVERD CHARGES	4,207.22	TOTAL MEDICAID LIAB	4,275.54
		LESS: COB	4,269.54
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	183.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	151.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,589.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,030.49	71.97
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	360.63	0.00	PROFESSIONAL FEES	0.00	1,737.37
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,621.91	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	808.34			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,347.79	4,207.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,347.79	4,207.22

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,907.19	ADJUSTMENTS	0.00
COVERED CHARGES	32,547.97	CONTRACTUAL ALLOW	26,898.11
NON-COVERD CHARGES	1,359.22	TOTAL MEDICAID LIAB	5,649.86
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,649.86

TOTAL NUMBER OF CLAIMS 1

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,908.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,152.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,671.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,495.81	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,981.38	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,207.71	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,253.94	1,359.22	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	966.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	145.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	765.00	0.00			
			TOTAL ANCILLARY	32,547.97	1,359.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,547.97	1,359.22

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

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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,968,678.61	ADJUSTMENTS	81,705.93
COVERED CHARGES	2,830,365.61	CONTRACTUAL ALLOW	1,610,792.10
NON-COVERD CHARGES	138,313.00	TOTAL MEDICAID LIAB	1,219,573.51
		LESS: COB	3,708.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,215,865.37

TOTAL NUMBER OF ADMISSIONS 190

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	564		0	364,344.00		90,736.00
ROUTINE NURSERY	62		0	34,892.00		578.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	626		0	399,236.00		91,314.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	82		0	108,730.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	82		0	108,730.00		0.00
TOTAL ACCOMODATIONS	708		0	507,966.00		91,314.00

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	364,277.12	0.00	OTHER LAB	16,471.00	0.00
MED/SURG SUPPLY	211,518.95	188.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	481,749.11	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,454.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	182,860.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,589.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,990.00	0.00	MRI SERVICES	32,172.00	0.00
IV THERAPY	39,340.00	0.00	PROFESSIONAL FEES	0.00	6,059.00
OPERATING ROOM	267,819.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	153,480.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	204,343.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,019.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	161,910.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,323.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,744.00	0.00	INJECTABLE DRUGS	5,074.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	597.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,117.25	2,660.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,910.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	15,815.00
OTHER IMAGING SERVICE	14,568.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,941.00	22,277.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	6,322.00	0.00			
CARDIOLOGY	14,323.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,487.00	0.00			
			TOTAL ANCILLARY	2,322,399.61	46,999.00
			TOTAL ACCOMODATIONS	507,966.00	91,314.00
			TOTAL CHARGES	2,830,365.61	138,313.00

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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016321000412	07/14/16 - 07/18/16	11/21/16	0.00	1,704.00	0.00	0.00	0.00
614	2216344007370	11/03/16 - 11/09/16	12/12/16	0.00	1,704.00	0.00	0.00	0.00
615	2217033001607	01/06/17 - 01/10/17	02/06/17	0.00	3,163.00	0.00	0.00	0.00
614	2217055004487	09/03/16 - 09/09/16	02/27/17	0.00	2,918.00	0.00	0.00	0.00
615	2217157007219	03/15/17 - 03/16/17	06/12/17	0.00	3,163.00	0.00	0.00	0.00
615	2217198008544	02/05/17 - 02/16/17	07/24/17	0.00	3,163.00	0.00	0.00	0.00
TOTAL				0.00	15,815.00	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: 08/29/2018
 Run Time: 00:38:34
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR
 1500 E SHOTWELL ST
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
 000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,320.68	ADJUSTMENTS	0.00
COVERED CHARGES	16,224.68	CONTRACTUAL ALLOW	6,076.71
NON-COVERD CHARGES	96.00	TOTAL MEDICAID LIAB	10,147.97
		LESS: COB	10,147.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,584.00		96.00
ROUTINE NURSERY	0		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	2,584.00		96.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	2,584.00		96.00

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,012.68	0.00	OTHER LAB	358.00	0.00
MED/SURG SUPPLY	486.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,316.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	10,468.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	13,640.68	0.00
			TOTAL ACCOMODATIONS	2,584.00	96.00
			TOTAL CHARGES	16,224.68	96.00

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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,169,765.26	ADJUSTMENTS	59,153.86
COVERED CHARGES	3,865,762.05	CONTRACTUAL ALLOW	3,047,998.43
NON-COVERD CHARGES	304,003.21	TOTAL MEDICAID LIAB	817,763.62
		LESS: COB	1,360.85
		LESS: COPAYMENT	2,291.51
		REIMBURSEMENT	814,111.26
		ALL OTHER	690,374.20
		FEE SCHEDULE-LAB	120,365.53
		INJECTABLE DRUGS	3,371.53
		TOTAL NUMBER OF CLAIMS	3,218

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR
 1500 E SHOTWELL ST
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER
 000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,944.50	25,469.21	OTHER LAB	71,173.00	0.00
MED/SURG SUPPLY	125,476.20	1,931.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	211,832.00	5,883.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	452,127.00	109,157.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,735.00	5,264.00	FEE SCHEDULE LAB	1,046,234.00	46,453.00
EKG/ECG	60,838.00	3,012.00	MRI SERVICES	101,413.00	13,745.00
IV THERAPY	160,857.00	7,254.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	244,525.50	18,376.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,607.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,313.00	10,729.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,130.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	868,058.00	4,539.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,097.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,221.35	9,713.50
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	12,030.45	2,669.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,680.00	5,552.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	14,475.00
OTHER IMAGING SERVICE	82,648.00	5,893.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,924.00	6,752.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,825.00	504.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	32,623.00	5,541.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,593.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	116,857.00	1,091.00			
			TOTAL ANCILLARY	3,865,762.05	304,003.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,865,762.05	304,003.21

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

Run Date: 08/29/2018
 Run Time: 00:38:34
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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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016316012772	11/04/16 - 11/04/16	11/14/16	0.00	2,676.00	0.00	0.00	0.00
614	2016343112905	12/02/16 - 12/02/16	12/12/16	0.00	2,310.00	0.00	0.00	0.00
615	2017003100952	12/27/16 - 12/27/16	01/09/17	0.00	1,217.00	0.00	0.00	0.00
615	2017003100952	12/27/16 - 12/27/16	01/09/17	0.00	1,946.00	0.00	0.00	0.00
615	2017037039855	01/11/17 - 01/11/17	02/13/17	0.00	1,217.00	0.00	0.00	0.00
615	2017037039855	01/11/17 - 01/11/17	02/13/17	0.00	1,946.00	0.00	0.00	0.00
615	2017082109898	11/07/16 - 11/07/16	03/27/17	0.00	1,217.00	0.00	0.00	0.00
615	2017082109898	11/07/16 - 11/07/16	03/27/17	0.00	1,946.00	0.00	0.00	0.00
TOTAL				0.00	14,475.00	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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,898.82	ADJUSTMENTS	0.00
COVERED CHARGES	34,501.22	CONTRACTUAL ALLOW	16,854.08
NON-COVERD CHARGES	9,397.60	TOTAL MEDICAID LIAB	17,647.14
		LESS: COB	17,622.10
		LESS: COPAYMENT	25.04
		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

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,009.17	726.60	OTHER LAB	1,534.00	0.00
MED/SURG SUPPLY	3,352.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,610.00	226.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,338.00	4,994.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,453.00	790.00
EKG/ECG	237.00	237.00	MRI SERVICES	0.00	0.00
IV THERAPY	520.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,390.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	188.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,774.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,613.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	92.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	841.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,068.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	550.00	356.00			
			TOTAL ANCILLARY	34,501.22	9,397.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,501.22	9,397.60

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

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016259006932	08/30/16 - 08/30/16	09/19/16	0.00	2,068.00	0.00	1,335.26	0.00
TOTAL				0.00	2,068.00	0.00	1,335.26	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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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	127,215.90	ADJUSTMENTS	0.00
COVERED CHARGES	124,886.90	CONTRACTUAL ALLOW	115,433.04
NON-COVERD CHARGES	2,329.00	TOTAL MEDICAID LIAB	9,453.86
		LESS: COB	36.69
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	9,135.17
		TOTAL NUMBER OF CLAIMS	169

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,889.05	76.00	OTHER LAB	353.00	0.00
MED/SURG SUPPLY	1,319.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,701.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,529.00	1,244.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,672.00	748.00
EKG/ECG	1,494.00	261.00	MRI SERVICES	0.00	0.00
IV THERAPY	223.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	601.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,546.00	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	445.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	114.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	124,886.90	2,329.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	124,886.90	2,329.00

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

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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,710.05	ADJUSTMENTS	0.00
COVERED CHARGES	3,180.55	CONTRACTUAL ALLOW	2,253.88
NON-COVERD CHARGES	529.50	TOTAL MEDICAID LIAB	926.67
		LESS: COB	923.67
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74.55	10.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	62.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	934.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	416.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,694.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,180.55	529.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,180.55	529.50

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

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	04/01/16	THROUGH	03/31/17
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

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	04/01/16	THROUGH	03/31/17
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

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER 000001273A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 01/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,213,754.66	ADJUSTMENTS	4,810,360.78
COVERED CHARGES	110,296,508.58	CONTRACTUAL ALLOW	70,621,954.83
NON-COVERD CHARGES	4,917,246.08	TOTAL MEDICAID LIAB	39,674,553.75
		LESS: COB	312,089.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	39,362,464.60

TOTAL NUMBER OF ADMISSIONS 3,330

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14,584		21	12,891,114.44		2,962,357.00
ROUTINE NURSERY	2,401		0	4,466,618.50		303,526.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.01
TOTAL ROUTINE	16,985		21	17,357,732.94		3,265,883.01
SPECIAL CARE SERVICES						
CCU	196		0	591,724.00		0.00
ICU	3,408		0	6,986,090.00		0.00
NICU	530		0	1,727,204.00		0.00
PED ICU	459		0	1,836,863.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	372		0	1,123,068.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,965		0	12,264,949.00		0.00
TOTAL ACCOMODATIONS	21,950		21	29,622,681.94		3,265,883.01

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

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

Run Date: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,109,922.65	0.00	OTHER LAB	619,949.16	0.00
MED/SURG SUPPLY	5,846,840.75	96,087.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,872,888.93	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,604,501.84	0.00	OTHER THERAPEUTIC SVC	2,903.00	80,990.00
CT SCAN	2,632,809.36	16,032.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	872,988.14	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	395,085.00	0.00	MRI SERVICES	935,760.02	0.00
IV THERAPY	852,086.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,098,486.36	1,710.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	785,539.00	0.00	REHAB THERAPY	15,288.00	0.00
RESPIRATORY SERVICES	5,221,550.76	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,929,260.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	279,645.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,511,169.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,577,740.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	219,595.48	0.00	INJECTABLE DRUGS	4,698,983.19	13,515.98
RADIOLOGY THERAPEUTIC	552,491.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	552,969.01	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	321,385.62	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,075,203.00	184,562.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,450.00	1,291.00	TRAUMA RESPONSE	0.00	342,200.00
PSYCHIATRIC SERVICES	2,373.00	0.00	IMPL DEV CHARGE PATIENTS	5,360,838.58	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	756,320.07	33,078.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,781,704.50	797,715.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	386,984.32	84,180.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,389,237.28	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	187,932.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	190,945.42	0.00			
			TOTAL ANCILLARY	80,673,826.64	1,651,363.07
			TOTAL ACCOMODATIONS	29,622,681.94	3,265,883.01
			TOTAL CHARGES	110,296,508.58	4,917,246.08

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER 000001273A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 01/31/18
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,606,592.47	ADJUSTMENTS	0.00
COVERED CHARGES	1,456,881.22	CONTRACTUAL ALLOW	653,040.65
NON-COVERD CHARGES	149,711.25	TOTAL MEDICAID LIAB	803,840.57
		LESS: COB	803,840.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	122		0	107,848.00		118,173.00
ROUTINE NURSERY	151		0	328,939.00		24,678.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	273		0	436,787.00		142,851.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	14		0	33,852.00		0.00
NICU	3		0	9,846.00		0.00
PED ICU	32		0	126,272.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	49		0	169,970.00		0.00
TOTAL ACCOMODATIONS	322		0	606,757.00		142,851.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,965.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40,258.34	1,124.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	88,266.21	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,108.00	0.00	OTHER THERAPEUTIC SVC	0.00	606.00
CT SCAN	8,011.08	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,688.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,024.00	0.00	MRI SERVICES	33,236.26	0.00
IV THERAPY	2,941.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	91,722.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,753.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136,309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	43,638.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,172.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,037.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,558.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	951.00	0.00	INJECTABLE DRUGS	78,699.19	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,637.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,416.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	91,548.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,842.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,465.00	5,130.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	600.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,929.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	877.10	0.00			
			TOTAL ANCILLARY	850,124.22	6,860.25
			TOTAL ACCOMODATIONS	606,757.00	142,851.00
			TOTAL CHARGES	1,456,881.22	149,711.25

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

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

Run Date: 08/29/2018
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SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,932,623.09	ADJUSTMENTS	1,084,172.15
COVERED CHARGES	29,920,528.56	CONTRACTUAL ALLOW	25,163,339.50
NON-COVERD CHARGES	5,012,094.53	TOTAL MEDICAID LIAB	4,757,189.06
		LESS: COB	73,408.69
		LESS: COPAYMENT	12,715.11
		REIMBURSEMENT	4,671,065.26
		ALL OTHER	3,983,453.62
		FEE SCHEDULE-LAB	446,191.49
		INJECTABLE DRUGS	241,420.15
		TOTAL NUMBER OF CLAIMS	11,978

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

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

Run Date: 08/29/2018
 Run Time: 00:03:25
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SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	699,296.03	0.00	OTHER LAB	772,737.58	1,762.00
MED/SURG SUPPLY	1,167,688.81	18,859.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,012.00
RADIOLOGY-DIAGNOSTIC	1,227,520.70	262,142.00	OTHER THERAPEUTIC SVC	2,317.00	72,191.00
CT SCAN	1,945,478.66	213,513.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	168,818.00	64,924.94	FEE SCHEDULE LAB	2,820,325.72	180,898.76
EKG/ECG	246,832.00	18,400.00	MRI SERVICES	772,511.02	142,170.02
IV THERAPY	995,629.00	35,526.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,940,281.05	622,542.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,204.00	23,290.00	REHAB THERAPY	0.00	156.00
RESPIRATORY SERVICES	168,475.00	24,726.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,516,401.00	341.00	AMBULANCE	0.00	0.00
GI SERVICES	261,520.00	56,861.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,688,535.00	36,899.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	863,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,400,124.12	1,298,264.29
RADIOLOGY THERAPEUTIC	1,910,822.77	742,753.55	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	100,660.00	81,263.48	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	32,610.00	21,257.53	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	19,002.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	75,198.00	76,417.00	TRAUMA RESPONSE	0.00	190,000.00
PSYCHIATRIC SERVICES	3,955.00	0.00	IMPL DEV CHARGE PATIENTS	416,668.34	0.00
LITHOTRIpsy	44,049.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,061,169.68	138,233.52			
BLOOD	976.00	0.00			
BLOOD STORAGE & PRO.	232,407.00	94,312.68			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	387,929.24	462,750.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	281,808.00	108,951.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	62,206.00	765.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	603,624.84	1,908.49			
			TOTAL ANCILLARY	29,920,528.56	5,012,094.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,920,528.56	5,012,094.53

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

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	615,606.18	ADJUSTMENTS	0.00
COVERED CHARGES	458,294.30	CONTRACTUAL ALLOW	279,596.70
NON-COVERD CHARGES	157,311.88	TOTAL MEDICAID LIAB	178,697.60
		LESS: COB	178,553.60
		LESS: COPAYMENT	144.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 174

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

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,164.62	0.00	OTHER LAB	32,900.32	0.00
MED/SURG SUPPLY	30,022.44	32.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,266.00	6,102.00	OTHER THERAPEUTIC SVC	0.00	1,419.00
CT SCAN	17,086.92	12,420.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,744.00	1,497.00	FEE SCHEDULE LAB	31,441.56	4,965.00
EKG/ECG	920.00	184.00	MRI SERVICES	33,160.32	1,717.80
IV THERAPY	16,021.00	1,453.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,453.00	40,315.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,212.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,183.00	560.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,945.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,329.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,188.00	590.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,996.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,171.89	54,181.79
RADIOLOGY THERAPEUTIC	41,456.00	15,911.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,643.00	667.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	691.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,794.00	2,791.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,474.14	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,381.36	808.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,750.00	10,683.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,237.46	286.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	765.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,588.27	36.84			
			TOTAL ANCILLARY	458,294.30	157,311.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	458,294.30	157,311.88

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: 08/29/2018
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SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	697,177.45	ADJUSTMENTS	279.70
COVERED CHARGES	676,983.51	CONTRACTUAL ALLOW	640,422.69
NON-COVERD CHARGES	20,193.94	TOTAL MEDICAID LIAB	36,560.82
		LESS: COB	1,534.11
		LESS: COPAYMENT	606.93
		REIMBURSEMENT	34,419.78
		TOTAL NUMBER OF CLAIMS	627

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,912.55	0.00	OTHER LAB	2,882.00	0.00
MED/SURG SUPPLY	255.00	163.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,398.45	8,432.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,194.54	2,164.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	68,106.48	2,650.80
EKG/ECG	3,496.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,032.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,505.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,110.00	112.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	493,047.00	590.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,707.45	215.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,947.96	5,866.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,429.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	597.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,363.08	0.00			
			TOTAL ANCILLARY	676,983.51	20,193.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	676,983.51	20,193.94

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: 08/29/2018
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SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,562.75	ADJUSTMENTS	0.00
COVERED CHARGES	16,375.42	CONTRACTUAL ALLOW	14,131.81
NON-COVERD CHARGES	187.33	TOTAL MEDICAID LIAB	2,243.61
		LESS: COB	2,228.61
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94.86	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	1,131.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,252.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,364.33	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	785.00	107.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,007.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	740.71	32.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,375.42	187.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,375.42	187.33

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

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,938,531.36	ADJUSTMENTS	495,169.80
COVERED CHARGES	8,295,480.08	CONTRACTUAL ALLOW	7,188,262.02
NON-COVERD CHARGES	643,051.28	TOTAL MEDICAID LIAB	1,107,218.06
		LESS: COB	52,640.89
		LESS: COPAYMENT	1,956.28
		REIMBURSEMENT	1,052,620.89
		TOTAL NUMBER OF CLAIMS	172

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

SAVANNAH HEALTH SERVICES, LLC
 4700 WATERS AVENUE
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER
 000001273A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,155.45	0.00	OTHER LAB	5,751.90	0.00
MED/SURG SUPPLY	474,208.23	4,954.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,668.00	26,684.00	OTHER THERAPEUTIC SVC	0.00	7,415.00
CT SCAN	11,337.94	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	940.00	962.02	FEE SCHEDULE LAB	58,518.15	2,637.80
EKG/ECG	1,104.00	736.00	MRI SERVICES	0.00	3,118.00
IV THERAPY	45,445.00	3,118.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,150,875.14	299,552.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	936.00
RESPIRATORY SERVICES	874.00	853.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	139,404.00	3,153.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,309.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,717.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,051,637.31	29,339.50
RADIOLOGY THERAPEUTIC	1,675,983.90	60,710.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	158.00	490.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	691.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,344.00	6,127.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,365,082.02	20,485.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,686.32	5,784.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,868.00	6,695.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,695.00	6,218.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	80,213.00	152,392.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,504.72	0.00			
			TOTAL ANCILLARY	8,295,480.08	643,051.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,295,480.08	643,051.28

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

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

Run Date: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAVANNAH HEALTH SERVICES, LLC
4700 WATERS AVENUE
SAVANNAH,GA 31404-6220

PROVIDER NUMBER
000001273A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	01/31/18
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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	162,223.58	ADJUSTMENTS	0.00
COVERED CHARGES	160,487.58	CONTRACTUAL ALLOW	64,005.48
NON-COVERD CHARGES	1,736.00	TOTAL MEDICAID LIAB	96,482.10
		LESS: COB	1,108.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	95,373.27

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	74		0	38,570.00		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	74		0	38,570.00		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	74		0	38,570.00		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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,012.40	0.00	OTHER LAB	602.00	0.00
MED/SURG SUPPLY	6,926.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,875.15	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,104.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,238.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	376.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,192.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,901.41	0.00	FREE STANDING CLINIC	0.00	0.00
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	27,614.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	844.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	235.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,002.00	0.00			
BLOOD	2,418.00	0.00			
BLOOD STORAGE & PRO.	1,551.40	1,736.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,025.00	0.00			
			TOTAL ANCILLARY	121,917.58	1,736.00
			TOTAL ACCOMODATIONS	38,570.00	0.00
			TOTAL CHARGES	160,487.58	1,736.00

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	579,706.95	ADJUSTMENTS	361.40
COVERED CHARGES	477,435.39	CONTRACTUAL ALLOW	321,196.45
NON-COVERD CHARGES	102,271.56	TOTAL MEDICAID LIAB	156,238.94
		LESS: COB	459.80
		LESS: COPAYMENT	354.03
		REIMBURSEMENT	155,425.11
		ALL OTHER	141,427.94
		FEE SCHEDULE-LAB	13,107.94
		INJECTABLE DRUGS	889.23

TOTAL NUMBER OF CLAIMS 518

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,312.00	7,273.00	OTHER LAB	3,492.00	0.00
MED/SURG SUPPLY	8,293.98	234.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,869.00	4,189.00	OTHER THERAPEUTIC SVC	0.00	11,980.00
CT SCAN	21,474.00	46,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	108,780.53	4,510.00
EKG/ECG	11,004.00	1,572.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,092.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,714.00	5,648.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,849.08	2,226.56	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,998.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	241,110.40	1,250.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	714.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,448.00	7,448.25
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	720.40	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,564.00	6,527.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	452.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	179.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	2,300.00			
			TOTAL ANCILLARY	477,435.39	102,271.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	477,435.39	102,271.56

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

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

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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,040.12	ADJUSTMENTS	0.00
COVERED CHARGES	6,816.15	CONTRACTUAL ALLOW	4,598.34
NON-COVERD CHARGES	2,223.97	TOTAL MEDICAID LIAB	2,217.81
		LESS: COB	2,217.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	293.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	98.15	160.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129.00	323.00	OTHER THERAPEUTIC SVC	0.00	164.00
CT SCAN	1,243.00	1,213.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	823.00	22.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,502.00	0.00	SPECIAL SERVICES	0.00	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	48.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,816.15	2,223.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,816.15	2,223.97

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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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,511.59	ADJUSTMENTS	0.00
COVERED CHARGES	39,949.09	CONTRACTUAL ALLOW	37,599.09
NON-COVERD CHARGES	5,562.50	TOTAL MEDICAID LIAB	2,350.00
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	2,248.00
		TOTAL NUMBER OF CLAIMS	47

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21.00	482.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	239.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	855.00	0.00	OTHER THERAPEUTIC SVC	0.00	164.00
CT SCAN	0.00	3,866.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,287.00	202.00
EKG/ECG	524.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	161.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.08	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,181.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,362.00	848.50
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
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	39,949.09	5,562.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,949.09	5,562.50

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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

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

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER HEALTHCARE, LLC
5995 SPRING ST
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER
000001284A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,572,644.93	ADJUSTMENTS	869.20
COVERED CHARGES	1,551,636.93	CONTRACTUAL ALLOW	852,589.44
NON-COVERD CHARGES	21,008.00	TOTAL MEDICAID LIAB	699,047.49
		LESS: COB	1,198.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	697,848.99

TOTAL NUMBER OF ADMISSIONS 87

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	411		0	156,525.00		770.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	411		0	156,525.00		770.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	411		0	156,525.00		770.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
 209 N CUTHBERT ST
 COLQUITT,GA 39837-3518

PROVIDER NUMBER 000001317A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	465,825.83	100.00	OTHER LAB	7,109.00	0.00
MED/SURG SUPPLY	259,508.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	255,264.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,077.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,277.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,389.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,739.00	0.00	MRI SERVICES	2,178.00	0.00
IV THERAPY	10,991.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,664.00	7,146.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101,696.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,379.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,211.76	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	615.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,733.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,325.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,040.00	12,992.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,204.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,886.00	0.00			
			TOTAL ANCILLARY	1,395,111.93	20,238.00
			TOTAL ACCOMODATIONS	156,525.00	770.00
			TOTAL CHARGES	1,551,636.93	21,008.00

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL
209 N CUTHBERT ST
COLQUITT,GA 39837-3518

PROVIDER NUMBER
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,579,757.04	ADJUSTMENTS	21,899.47
COVERED CHARGES	3,990,643.77	CONTRACTUAL ALLOW	2,424,236.09
NON-COVERD CHARGES	589,113.27	TOTAL MEDICAID LIAB	1,566,407.68
		LESS: COB	316.05
		LESS: COPAYMENT	993.00
		REIMBURSEMENT	1,565,098.63
		ALL OTHER	1,398,066.36
		FEE SCHEDULE-LAB	167,010.56
		INJECTABLE DRUGS	21.71
		TOTAL NUMBER OF CLAIMS	6,042

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

MILLER COUNTY HOSPITAL
 209 N CUTHBERT ST
 COLQUITT,GA 39837-3518

PROVIDER NUMBER
 000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,589.85	161,711.69	OTHER LAB	40,893.00	0.00
MED/SURG SUPPLY	342,694.92	2,420.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	687.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250,110.00	10,251.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	182,175.00	28,126.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,186.00	1,109.00	FEE SCHEDULE LAB	1,098,687.00	121,484.00
EKG/ECG	13,467.00	654.00	MRI SERVICES	19,602.00	0.00
IV THERAPY	22,311.00	5,933.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	828,133.00	64,986.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,171.00	3,059.00	FREE STANDING CLINIC	39.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	158,237.00	24,774.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	176,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45.00	347.35
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	1,570.03	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	8,321.00	310.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	70.00
OTHER IMAGING SERVICE	18,531.00	722.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,084.00	13,188.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,857.00	3,851.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,250.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	708,510.00	143,860.00			
			TOTAL ANCILLARY	3,990,643.77	589,113.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,990,643.77	589,113.27

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217089008323	02/27/17 - 02/27/17	04/03/17	0.00	70.00	0.00	0.00	0.00
TOTAL				0.00	70.00	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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,200.40	ADJUSTMENTS	0.00
COVERED CHARGES	22,372.70	CONTRACTUAL ALLOW	2,421.20
NON-COVERD CHARGES	4,827.70	TOTAL MEDICAID LIAB	19,951.50
		LESS: COB	19,948.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 46

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	275.70	1,126.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	760.00	67.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,017.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,401.00	1,243.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,093.00	1,542.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	260.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,820.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	548.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	746.00	301.00			
			TOTAL ANCILLARY	22,372.70	4,827.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,372.70	4,827.70

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,135.25	ADJUSTMENTS	0.00
COVERED CHARGES	65,861.80	CONTRACTUAL ALLOW	60,535.80
NON-COVERD CHARGES	3,273.45	TOTAL MEDICAID LIAB	5,326.00
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	5,137.00
		TOTAL NUMBER OF CLAIMS	113

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,277.20	699.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,845.60	188.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,555.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,645.00	1,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,755.00	534.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	699.00	207.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,901.00	176.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,184.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	65,861.80	3,273.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,861.80	3,273.45

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: 08/29/2018
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Page: 11

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	07/01/16	THROUGH	06/30/17
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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,231.90	ADJUSTMENTS	0.00
COVERED CHARGES	38,982.35	CONTRACTUAL ALLOW	24,113.12
NON-COVERD CHARGES	10,249.55	TOTAL MEDICAID LIAB	14,869.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,869.23

TOTAL NUMBER OF CLAIMS 3

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	883.00	2,948.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,284.35	34.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,253.00	290.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,728.00	868.00
EKG/ECG	109.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	260.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,676.00	1,200.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,051.00	1,528.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82.00	394.00	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	2,084.85
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.	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	16,954.00	438.00			
			TOTAL ANCILLARY	38,982.35	10,249.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,982.35	10,249.55

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC
 5401 LAKE OCONEE PARKWAY
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER 000001328A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	426,495.61	ADJUSTMENTS	19,273.15
COVERED CHARGES	397,957.61	CONTRACTUAL ALLOW	200,213.96
NON-COVERD CHARGES	28,538.00	TOTAL MEDICAID LIAB	197,743.65
		LESS: COB	2,995.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	194,748.34

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	98		0	100,940.00		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	98		0	100,940.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	98		0	100,940.00		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,102.76	0.00	OTHER LAB	5,058.00	0.00
MED/SURG SUPPLY	4,565.00	151.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	74,875.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,056.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,181.00	22,623.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,107.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,172.00	0.00	MRI SERVICES	13,305.00	0.00
IV THERAPY	9,443.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,646.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,772.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,804.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,879.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,635.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	332.00	0.00	INJECTABLE DRUGS	3,409.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	804.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	801.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,764.00
OTHER IMAGING SERVICE	916.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,564.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,408.00	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	116.00	0.00			
			TOTAL ANCILLARY	297,017.61	28,538.00
			TOTAL ACCOMODATIONS	100,940.00	0.00
			TOTAL CHARGES	397,957.61	28,538.00

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

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

Run Date: 08/29/2018
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SUMMARY TYPE I
INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC
5401 LAKE OCONEE PARKWAY
GREENSBORO,GA 30642-4232

PROVIDER NUMBER
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017048072006	09/08/16 - 09/12/16	02/27/17	0.00	2,531.00	0.00	0.00	0.00
614	2017153104800	05/22/17 - 05/26/17	06/12/17	0.00	3,233.00	0.00	0.00	0.00
TOTAL				0.00	5,764.00	0.00	0.00	0.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,499.34	ADJUSTMENTS	0.00
COVERED CHARGES	37,499.34	CONTRACTUAL ALLOW	27,515.34
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,984.00
		LESS: COB	9,984.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	9,270.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	9,270.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	9		0	9,270.00		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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	543.50	0.00	OTHER LAB	481.00	0.00
MED/SURG SUPPLY	1,404.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,665.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	788.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	402.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	564.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,556.00	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	601.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,432.84	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.	792.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,229.34	0.00
			TOTAL ACCOMODATIONS	9,270.00	0.00
			TOTAL CHARGES	37,499.34	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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,882,856.93	ADJUSTMENTS	3,196.33
COVERED CHARGES	1,724,422.20	CONTRACTUAL ALLOW	1,303,167.45
NON-COVERD CHARGES	158,434.73	TOTAL MEDICAID LIAB	421,254.75
		LESS: COB	375.13
		LESS: COPAYMENT	1,011.00
		REIMBURSEMENT	419,868.62
		ALL OTHER	372,579.82
		FEE SCHEDULE-LAB	41,649.76
		INJECTABLE DRUGS	5,639.04
		TOTAL NUMBER OF CLAIMS	1,303

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,381.41	0.00	OTHER LAB	13,277.00	481.00
MED/SURG SUPPLY	10,156.00	6,985.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	90,380.00	4,758.00	OTHER THERAPEUTIC SVC	0.00	173.00
CT SCAN	246,237.00	24,527.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,271.00	8,389.00	FEE SCHEDULE LAB	317,938.00	13,695.00
EKG/ECG	20,938.00	1,937.00	MRI SERVICES	84,958.00	2,171.00
IV THERAPY	88,105.00	475.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,167.00	22,823.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,907.00	198.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,568.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	379,926.00	2,066.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,598.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	102,225.79	40,529.73
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	726.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,353.00
LITHOTRIPSY	8,671.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,246.00	7,106.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,808.00	6,230.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	44,007.00	10,386.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,686.00	1,426.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,416.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,555.00	0.00			
			TOTAL ANCILLARY	1,724,422.20	158,434.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,724,422.20	158,434.73

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,561.26	ADJUSTMENTS	0.00
COVERED CHARGES	11,909.55	CONTRACTUAL ALLOW	3,194.84
NON-COVERD CHARGES	5,651.71	TOTAL MEDICAID LIAB	8,714.71
		LESS: COB	8,705.71
		LESS: COPAYMENT	9.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	685.90	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	140.00	406.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,391.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,768.00	51.00
EKG/ECG	149.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,878.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,863.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,043.65	511.71
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	382.00	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	11,909.55	5,651.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,909.55	5,651.71

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,264.51	ADJUSTMENTS	97.00
COVERED CHARGES	93,046.11	CONTRACTUAL ALLOW	87,496.11
NON-COVERD CHARGES	1,218.40	TOTAL MEDICAID LIAB	5,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	164.10
		REIMBURSEMENT	5,385.90
		TOTAL NUMBER OF CLAIMS	111

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	979.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,629.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,479.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,843.00	67.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,450.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	132.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,186.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,162.16	123.40
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	1,887.00	1,028.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	93,046.11	1,218.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,046.11	1,218.40

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,158.08	ADJUSTMENTS	0.00
COVERED CHARGES	2,077.10	CONTRACTUAL ALLOW	916.44
NON-COVERD CHARGES	80.98	TOTAL MEDICAID LIAB	1,160.66
		LESS: COB	1,156.78
		LESS: COPAYMENT	3.88
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC
 5401 LAKE OCONEE PARKWAY
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	447.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	631.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	519.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	478.60	80.98
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,077.10	80.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,077.10	80.98

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,353.14	ADJUSTMENTS	4,982.44
COVERED CHARGES	78,558.99	CONTRACTUAL ALLOW	58,617.23
NON-COVERD CHARGES	2,794.15	TOTAL MEDICAID LIAB	19,941.76
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	19,932.76

TOTAL NUMBER OF CLAIMS 4

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,401.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,786.00	393.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	290.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,619.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,658.00	0.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,782.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,945.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,919.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,713.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,975.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,120.26	166.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	616.00
LITHOTRIPSY	8,671.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,558.99	2,794.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,558.99	2,794.15

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

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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,524.00	ADJUSTMENTS	0.00
COVERED CHARGES	26,408.00	CONTRACTUAL ALLOW	9,590.95
NON-COVERD CHARGES	116.00	TOTAL MEDICAID LIAB	16,817.05
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,817.05

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	4,299.00		116.00
ROUTINE NURSERY	0		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	4,299.00		116.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,299.00		116.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,796.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	563.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,521.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,120.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	531.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	522.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,465.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	591.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,109.00	0.00
			TOTAL ACCOMODATIONS	4,299.00	116.00
			TOTAL CHARGES	26,408.00	116.00

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 10/01/16 THROUGH 09/30/17
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: 08/29/2018
Run Time: 00:54:01
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,693,845.40	ADJUSTMENTS	26,820.58
COVERED CHARGES	1,603,734.64	CONTRACTUAL ALLOW	1,279,707.67
NON-COVERD CHARGES	90,110.76	TOTAL MEDICAID LIAB	324,026.97
		LESS: COB	1,118.34
		LESS: COPAYMENT	1,095.00
		REIMBURSEMENT	321,813.63
		ALL OTHER	268,866.17
		FEE SCHEDULE-LAB	47,415.72
		INJECTABLE DRUGS	5,531.74
		TOTAL NUMBER OF CLAIMS	1,770

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,790.80	1.09	OTHER LAB	1,714.00	0.00
MED/SURG SUPPLY	19,278.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	138,713.00	2,579.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	217,263.00	45,267.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,443.00	7,659.00	FEE SCHEDULE LAB	438,989.94	11,848.00
EKG/ECG	17,523.00	0.00	MRI SERVICES	9,612.00	1,241.00
IV THERAPY	97,933.00	1,921.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,636.00	2,759.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	356,465.34	1,557.66	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	47,259.56	4,039.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,636.00	5,329.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,006.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,155.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	69.00	0.00
OTHER IMAGING SERVICE	43,204.00	2,236.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504.00	1,512.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,656.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,045.00	0.00			
			TOTAL ANCILLARY	1,603,734.64	90,110.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,603,734.64	90,110.76

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017249047579	08/30/17 - 08/30/17	11/13/17	69.00	0.00	0.00	0.00	20.52
TOTAL				69.00	0.00	0.00	0.00	20.52

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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL
90 E STEPHENS ST
CAMILLA,GA 31730-1836

PROVIDER NUMBER
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,915.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,516.00	CONTRACTUAL ALLOW	4,980.46
NON-COVERD CHARGES	3,399.00	TOTAL MEDICAID LIAB	6,535.54
		LESS: COB	6,532.54
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46.00	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	652.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,961.00	84.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	904.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,220.00	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	235.00	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	140.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,516.00	3,399.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,516.00	3,399.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,507.69	ADJUSTMENTS	0.00
COVERED CHARGES	42,475.69	CONTRACTUAL ALLOW	39,075.69
NON-COVERD CHARGES	1,032.00	TOTAL MEDICAID LIAB	3,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	3,319.00
		TOTAL NUMBER OF CLAIMS	68

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	159.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,151.00	316.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,612.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,589.00	701.00
EKG/ECG	354.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,260.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	19,567.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,014.69	15.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	343.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,475.69	1,032.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,475.69	1,032.00

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	616.00	ADJUSTMENTS	0.00
COVERED CHARGES	616.00	CONTRACTUAL ALLOW	144.78
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	471.22
		LESS: COB	471.22
		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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	274.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	301.00	0.00	SPECIAL SERVICES	0.00	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	616.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	616.00	0.00

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,499.00	ADJUSTMENTS	0.00
COVERED CHARGES	51,499.00	CONTRACTUAL ALLOW	41,586.18
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,912.82
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	9,906.82
		TOTAL NUMBER OF CLAIMS	2

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,438.00	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	6,061.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	51,499.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,499.00	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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
 Run Time: 00:51:51
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,174.85	ADJUSTMENTS	4,134.03
COVERED CHARGES	101,822.85	CONTRACTUAL ALLOW	44,520.87
NON-COVERD CHARGES	352.00	TOTAL MEDICAID LIAB	57,301.98
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	57,301.98

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	29		0	13,485.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	29		0	13,485.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	908.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	908.00		0.00
TOTAL ACCOMODATIONS	31		0	14,393.00		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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,725.00	0.00	OTHER LAB	749.00	0.00
MED/SURG SUPPLY	4,178.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,538.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,346.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,393.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,765.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,699.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,735.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,078.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,575.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	648.00	352.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	87,429.85	352.00
			TOTAL ACCOMODATIONS	14,393.00	0.00
			TOTAL CHARGES	101,822.85	352.00

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL
88 MARTIN LUTHER KING JR DR
FORSYTH,GA 31029-1682

PROVIDER NUMBER
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	585,846.88	ADJUSTMENTS	10,938.38
COVERED CHARGES	510,015.70	CONTRACTUAL ALLOW	328,855.43
NON-COVERD CHARGES	75,831.18	TOTAL MEDICAID LIAB	181,160.27
		LESS: COB	336.33
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	180,580.94
		ALL OTHER	168,087.76
		FEE SCHEDULE-LAB	10,677.56
		INJECTABLE DRUGS	1,815.62

TOTAL NUMBER OF CLAIMS 480

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,125.00	10,513.68	OTHER LAB	3,454.00	0.00
MED/SURG SUPPLY	4,266.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	108.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,364.00	572.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	96,896.00	41,324.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	84,177.00	6,133.00
EKG/ECG	7,381.00	486.00	MRI SERVICES	1,952.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,765.00	4,798.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	975.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	8,265.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	182,587.00	1,524.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,665.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,577.78	715.50
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	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	16.00
OTHER IMAGING SERVICE	9,092.00	617.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,705.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	906.00	558.00			
			TOTAL ANCILLARY	510,015.70	75,831.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	510,015.70	75,831.18

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
308	5917096001259	11/28/16 - 11/28/16	04/10/17	0.00	16.00	0.00	0.00	0.00
TOTAL				0.00	16.00	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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,811.83	ADJUSTMENTS	0.00
COVERED CHARGES	3,007.83	CONTRACTUAL ALLOW	-35.57
NON-COVERD CHARGES	2,804.00	TOTAL MEDICAID LIAB	3,043.40
		LESS: COB	3,043.40
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	483.00	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	0.00	2,576.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	573.00	228.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,245.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	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	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,007.83	2,804.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,007.83	2,804.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	98,816.40	ADJUSTMENTS	47.00
COVERED CHARGES	92,017.40	CONTRACTUAL ALLOW	85,017.40
NON-COVERD CHARGES	6,799.00	TOTAL MEDICAID LIAB	7,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	345.00
		REIMBURSEMENT	6,655.00
		TOTAL NUMBER OF CLAIMS	140

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,688.00	1,845.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	160.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	43.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,296.00	572.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,428.00	3,713.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,633.00	418.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,628.00	168.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,184.00	40.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	92,017.40	6,799.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,017.40	6,799.00

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	775.20	ADJUSTMENTS	0.00
COVERED CHARGES	775.20	CONTRACTUAL ALLOW	434.92
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	340.28
		LESS: COB	340.28
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	252.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	520.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	775.20	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	775.20	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

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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
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

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	715,747.81	ADJUSTMENTS	0.00
COVERED CHARGES	663,334.42	CONTRACTUAL ALLOW	472,934.68
NON-COVERD CHARGES	52,413.39	TOTAL MEDICAID LIAB	190,399.74
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	190,399.74

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	77		0	60,907.00		11,320.54
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	77		0	60,907.00		11,320.54
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	77		0	60,907.00		11,320.54

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,052.80	0.00	OTHER LAB	3,396.04	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	152,751.16	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,866.12	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,013.77	41,092.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	788.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	38,425.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,200.82	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	128,806.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,976.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	146,502.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,505.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,912.16	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	230.97	0.00			
			TOTAL ANCILLARY	602,427.42	41,092.85
			TOTAL ACCOMODATIONS	60,907.00	11,320.54
			TOTAL CHARGES	663,334.42	52,413.39

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,837,183.11	ADJUSTMENTS	77,798.13
COVERED CHARGES	5,437,616.23	CONTRACTUAL ALLOW	4,458,272.55
NON-COVERD CHARGES	399,566.88	TOTAL MEDICAID LIAB	979,343.68
		LESS: COB	150.00
		LESS: COPAYMENT	1,160.06
		REIMBURSEMENT	978,033.62
		ALL OTHER	912,399.99
		FEE SCHEDULE-LAB	57,360.75
		INJECTABLE DRUGS	8,272.88
		TOTAL NUMBER OF CLAIMS	1,670

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,580.12	6,870.98	OTHER LAB	13,225.72	0.00
MED/SURG SUPPLY	10,056.94	932.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	399,533.22	2,471.73	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,086,791.56	107,944.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	263,010.57	4,171.00	FEE SCHEDULE LAB	1,082,726.70	53,534.35
EKG/ECG	131,216.00	6,037.96	MRI SERVICES	46,427.88	0.00
IV THERAPY	389,712.09	58,619.74	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	169,847.00	49,686.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,386.02	3,708.97	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,462.10	2,152.00	AMBULANCE	0.00	0.00
GI SERVICES	3,198.00	3,615.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,482,114.88	10,251.22	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,208.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	174,600.82	55,811.30
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	2,267.18	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	19,425.14
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,908.80	7,798.26			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	851.22	1,713.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,491.94	2,325.75			
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	45,266.65	229.74			
			TOTAL ANCILLARY	5,437,616.23	399,566.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,437,616.23	399,566.88

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

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,935.41	ADJUSTMENTS	0.00
COVERED CHARGES	5,935.41	CONTRACTUAL ALLOW	5,129.41
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	806.00
		LESS: COB	806.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

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

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	1,966.80	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,957.22	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11.39	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,935.41	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,935.41	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: 08/29/2018
Run Time: 00:10:11
Page: 8

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	434,616.86	ADJUSTMENTS	52.94
COVERED CHARGES	408,762.45	CONTRACTUAL ALLOW	394,945.27
NON-COVERD CHARGES	25,854.41	TOTAL MEDICAID LIAB	13,817.18
		LESS: COB	0.00
		LESS: COPAYMENT	485.31
		REIMBURSEMENT	13,331.87
		TOTAL NUMBER OF CLAIMS	247

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321.07	190.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,415.93	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	56,638.41	15,526.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	74,975.08	6,434.00
EKG/ECG	5,752.24	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,205.10	1,084.50	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	997.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,758.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,664.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	206,415.49	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	827.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,951.70	955.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,505.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	408,762.45	25,854.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	408,762.45	25,854.41

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

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

Run Date: 08/29/2018
Run Time: 00:10:12
Page: 10

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/29/2018
Run Time: 00:10:13
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC
707 OLD DALTON ELLIJAY RD
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	327,759.58	ADJUSTMENTS	26,658.90
COVERED CHARGES	273,102.62	CONTRACTUAL ALLOW	235,750.76
NON-COVERD CHARGES	54,656.96	TOTAL MEDICAID LIAB	37,351.86
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	37,318.86
		TOTAL NUMBER OF CLAIMS	7

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

ADVENTIST HEALTH SYSTEM GEORGIA INC
 707 OLD DALTON ELLIJAY RD
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	705.03	212.31	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,797.69	725.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	636.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,246.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,833.59	79.22
EKG/ECG	1,447.58	1,276.16	MRI SERVICES	0.00	0.00
IV THERAPY	1,807.16	567.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	148,508.67	18,249.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	560.80	199.48	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,374.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,431.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,225.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,152.96	708.05
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	1,836.62	32,639.43
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,539.80	0.00			
			TOTAL ANCILLARY	273,102.62	54,656.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	273,102.62	54,656.96

Report : 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: 08/29/2018
Run Time: 00:10:13
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
 Run Time: 00:41:37
 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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	166,864,628.45	ADJUSTMENTS	14,543,424.96
COVERED CHARGES	159,672,886.25	CONTRACTUAL ALLOW	124,709,026.52
NON-COVERD CHARGES	7,191,742.20	TOTAL MEDICAID LIAB	34,963,859.73
		LESS: COB	365,381.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,598,478.64

TOTAL NUMBER OF ADMISSIONS 5,656

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,796		0	12,613,837.00		1,295,946.00
ROUTINE NURSERY	9,325		0	16,354,514.50		2,167,771.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	20,121		0	28,968,351.50		3,463,717.00
SPECIAL CARE SERVICES						
CCU	12		0	50,292.00		0.00
ICU	2,949		0	11,636,858.00		415,733.00
NICU	1,433		0	8,852,365.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,394		0	20,539,515.00		415,733.00
TOTAL ACCOMODATIONS	24,515		0	49,507,866.50		3,879,450.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL
 1000 JOHNSON FERRY RD NE
 ATLANTA,GA 30342-1606

PROVIDER NUMBER
 000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,591,715.12	422,802.70	OTHER LAB	517,956.00	2,171.00
MED/SURG SUPPLY	5,046,421.97	166,049.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,186,884.72	244,910.00	EDUCATION & TRAINING	14,216.00	952.00
RADIOLOGY-DIAGNOSTIC	1,543,507.50	7,548.00	OTHER THERAPEUTIC SVC	0.00	181,382.00
CT SCAN	2,824,609.00	27,162.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,124,093.00	33,980.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	322,504.00	2,800.00	MRI SERVICES	1,068,055.00	5,025.00
IV THERAPY	331,278.00	20,798.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,403,793.00	146,293.00	DURABLE MED. EQUIP.	0.00	4,096.00
LABOR/DELIVERY ROOM	9,223,201.00	6,224.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,082,737.00	123,001.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,311,720.50	870.00	AMBULANCE	0.00	0.00
GI SERVICES	14,994.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,385,723.00	1,325.00	SPECIAL SERVICES	0.00	25,088.00
RECOVERY ROOM	1,812,130.00	606.00	DRUG-SPECIFIC/HOME IV	0.00	33,219.00
LABORATORY PATHOLOGIC	1,628,959.00	0.00	INJECTABLE DRUGS	25,578,776.44	392,256.50
RADIOLOGY THERAPEUTIC	322,895.00	489.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	916,064.00	23,655.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	349,260.00	7,266.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	322,057.00	28,717.00	PATIENT CONVENIENCE	0.00	4,606.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	320.00	4,043.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	419.00	0.00	IMPL DEV CHARGE PATIENTS	880,507.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	875,022.00	102,731.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,141,788.00	1,237,037.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	306,812.00	50,895.00			
AUDIOLOGY	744,230.00	0.00			
CARDIOLOGY	1,516,941.50	2,732.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	63,058.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	712,372.00	1,562.00			
			TOTAL ANCILLARY	110,165,019.75	3,312,292.20
			TOTAL ACCOMODATIONS	49,507,866.50	3,879,450.00
			TOTAL CHARGES	159,672,886.25	7,191,742.20

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,980,677.73	ADJUSTMENTS	0.00
COVERED CHARGES	15,487,071.73	CONTRACTUAL ALLOW	9,779,463.23
NON-COVERD CHARGES	493,606.00	TOTAL MEDICAID LIAB	5,707,608.50
		LESS: COB	5,707,608.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 117

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	217		6	249,661.00		27,305.00
ROUTINE NURSERY	959		0	3,858,961.00		406,250.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,176		6	4,108,622.00		433,555.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	114		0	481,736.00		0.00
NICU	680		0	4,319,736.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	794		0	4,801,472.00		0.00
TOTAL ACCOMODATIONS	1,970		6	8,910,094.00		433,555.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,497,736.08	0.00	OTHER LAB	137,400.00	0.00
MED/SURG SUPPLY	418,302.00	4,613.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,000,801.24	0.00	EDUCATION & TRAINING	1,426.00	0.00
RADIOLOGY-DIAGNOSTIC	272,240.50	0.00	OTHER THERAPEUTIC SVC	0.00	11,323.00
CT SCAN	47,830.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,903.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,768.00	0.00	MRI SERVICES	32,193.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	327,385.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	287,946.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,214,412.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,565.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,233.00	0.00	SPECIAL SERVICES	0.00	41,193.00
RECOVERY ROOM	53,845.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	18,591.00	0.00	INJECTABLE DRUGS	546,811.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	126,722.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	44,101.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,209.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	175.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,317.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,805.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	135,319.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,330.00	538.00			
AUDIOLOGY	39,966.00	0.00			
CARDIOLOGY	150,644.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,382.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,576,977.73	60,051.00
			TOTAL ACCOMODATIONS	8,910,094.00	433,555.00
			TOTAL CHARGES	15,487,071.73	493,606.00

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

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

Run Date: 08/29/2018
Run Time: 00:42:05
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,050,380.21	ADJUSTMENTS	1,891,693.46
COVERED CHARGES	34,853,635.12	CONTRACTUAL ALLOW	27,538,172.33
NON-COVERD CHARGES	3,196,745.09	TOTAL MEDICAID LIAB	7,315,462.79
		LESS: COB	47,898.94
		LESS: COPAYMENT	24,584.81
		REIMBURSEMENT	7,242,979.04
		ALL OTHER	4,790,276.87
		FEE SCHEDULE-LAB	703,608.23
		INJECTABLE DRUGS	1,749,093.94

TOTAL NUMBER OF CLAIMS 10,297

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	417,716.30	10,751.15	OTHER LAB	177,224.00	2,398.00
MED/SURG SUPPLY	834,958.72	7,821.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	134.00	EDUCATION & TRAINING	1,377.00	296.00
RADIOLOGY-DIAGNOSTIC	569,517.00	7,811.00	OTHER THERAPEUTIC SVC	0.00	2,058.00
CT SCAN	2,681,405.00	343,118.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,078.00	25,565.00	FEE SCHEDULE LAB	10,564,598.55	329,951.00
EKG/ECG	173,708.00	2,118.00	MRI SERVICES	2,313,320.00	99,672.00
IV THERAPY	2,879,527.00	70,531.00	PROFESSIONAL FEES	0.00	419.00
OPERATING ROOM	1,998,480.00	344,094.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	120,964.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75,838.00	7,990.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	478,030.00	7,543.00	AMBULANCE	0.00	0.00
GI SERVICES	39,326.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,205,778.89	44,316.00	SPECIAL SERVICES	0.00	800.00
RECOVERY ROOM	394,783.00	1,482.00	DRUG-SPECIFIC/HOME IV	0.00	115.77
LABORATORY PATHOLOGIC	0.00	142.44	INJECTABLE DRUGS	2,902,185.05	1,106,672.73
RADIOLOGY THERAPEUTIC	894,121.00	116,090.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,442.00	26,915.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,320.00	3,813.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,150.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	617,228.00	101,261.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	84,603.00	29,630.00	IMPL DEV CHARGE PATIENTS	154,256.00	7,255.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,587,433.00	301,398.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	743,729.00	15,388.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,643.00	23,418.00			
AUDIOLOGY	7,304.00	0.00			
CARDIOLOGY	103,235.00	111,260.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,141.00	0.00			
ORGAN ACQUISITION	0.00	17,787.00			
TREATMENT/OBSERV. RM	680,365.61	9,581.00			
			TOTAL ANCILLARY	34,853,635.12	3,196,745.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,853,635.12	3,196,745.09

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,522,400.31	ADJUSTMENTS	0.00
COVERED CHARGES	781,377.34	CONTRACTUAL ALLOW	217,391.16
NON-COVERD CHARGES	741,022.97	TOTAL MEDICAID LIAB	563,986.18
		LESS: COB	563,610.11
		LESS: COPAYMENT	376.07
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 221

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,760.56	0.00	OTHER LAB	13,923.00	0.00
MED/SURG SUPPLY	33,335.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	355.00	148.00
RADIOLOGY-DIAGNOSTIC	12,620.00	886.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,484.00	69,242.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	172,644.00	5,674.00
EKG/ECG	2,800.00	0.00	MRI SERVICES	0.00	4,087.00
IV THERAPY	49,838.00	558.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	53,545.00	121,818.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,102.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	470.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,655.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	83,981.00	44,364.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,660.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105,951.78	396,628.97
RADIOLOGY THERAPEUTIC	3,032.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,650.00	893.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	620.00	264.00	IMPL DEV CHARGE PATIENTS	3,388.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,768.00	55,837.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,918.00	17,372.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,830.00	5,464.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,627.00	0.00			
ORGAN ACQUISITION	0.00	17,787.00			
TREATMENT/OBSERV. RM	8,420.00	0.00			
			TOTAL ANCILLARY	781,377.34	741,022.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	781,377.34	741,022.97

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	597,351.84	ADJUSTMENTS	2,059.69
COVERED CHARGES	567,977.79	CONTRACTUAL ALLOW	557,293.25
NON-COVERD CHARGES	29,374.05	TOTAL MEDICAID LIAB	10,684.54
		LESS: COB	0.00
		LESS: COPAYMENT	315.03
		REIMBURSEMENT	10,369.51
		TOTAL NUMBER OF CLAIMS	191

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,246.61	0.00	OTHER LAB	3,013.00	0.00
MED/SURG SUPPLY	6,932.00	344.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,471.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,961.00	10,291.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	132,948.00	919.00
EKG/ECG	5,968.00	0.00	MRI SERVICES	8,174.00	0.00
IV THERAPY	584.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,175.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,190.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,658.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	259,367.00	3,478.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,105.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,681.38	703.05
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	32,716.00	13,639.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,787.80	0.00			
			TOTAL ANCILLARY	567,977.79	29,374.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	567,977.79	29,374.05

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,794.74	ADJUSTMENTS	0.00
COVERED CHARGES	47,576.74	CONTRACTUAL ALLOW	29,172.73
NON-COVERD CHARGES	8,218.00	TOTAL MEDICAID LIAB	18,404.01
		LESS: COB	18,376.07
		LESS: COPAYMENT	27.94
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	245.68	0.00	OTHER LAB	1,329.00	0.00
MED/SURG SUPPLY	276.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	519.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,733.00	2,646.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,027.00	1,184.00
EKG/ECG	350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,205.00	2,441.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	368.06	1,050.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,524.00	897.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	47,576.74	8,218.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,576.74	8,218.00

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,210,575.67	ADJUSTMENTS	569,465.19
COVERED CHARGES	6,723,746.07	CONTRACTUAL ALLOW	5,010,617.26
NON-COVERD CHARGES	486,829.60	TOTAL MEDICAID LIAB	1,713,128.81
		LESS: COB	31,265.61
		LESS: COPAYMENT	2,238.00
		REIMBURSEMENT	1,679,625.20

TOTAL NUMBER OF CLAIMS 307

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

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

Run Date: 08/29/2018
 Run Time: 00:42:43
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,639.53	1,569.00	OTHER LAB	1,581.00	0.00
MED/SURG SUPPLY	323,513.79	1,666.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,985.00	16,804.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,990.00	24,226.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,858.00	FEE SCHEDULE LAB	570,711.00	10,284.00
EKG/ECG	8,050.00	350.00	MRI SERVICES	16,348.00	5,025.00
IV THERAPY	692,462.00	26,479.00	PROFESSIONAL FEES	0.00	186.00
OPERATING ROOM	773,666.00	94,690.00	DURABLE MED. EQUIP.	0.00	3,625.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,739.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	112,590.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,576.00	29.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,064.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,776,522.21	245,865.60
RADIOLOGY THERAPEUTIC	406,050.00	4,910.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,552.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,395.00	10,715.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	527,172.00	3,361.00
LITHOTRIpsy	44,480.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,054.00	11,865.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	50,993.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,168.00	1,870.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	92,768.00	19,900.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	60,228.54	0.00			
			TOTAL ANCILLARY	6,723,746.07	486,829.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,723,746.07	486,829.60

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	204,773.50	ADJUSTMENTS	0.00
COVERED CHARGES	201,341.50	CONTRACTUAL ALLOW	67,613.76
NON-COVERD CHARGES	3,432.00	TOTAL MEDICAID LIAB	133,727.74
		LESS: COB	133,697.74
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

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

Run Date: 08/29/2018
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL
 1000 JOHNSON FERRY RD NE
 ATLANTA,GA 30342-1606

PROVIDER NUMBER
 000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	5,214.00	58.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,466.00	744.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	176,999.50	2,630.00
RADIOLOGY THERAPEUTIC	2,295.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,225.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142.00	0.00			
			TOTAL ANCILLARY	201,341.50	3,432.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	201,341.50	3,432.00

** END OF REPORT **

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

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

Run Date: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
 361 RANDOLPH ST
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER 000001427A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	225,150.43	ADJUSTMENTS	0.00
COVERED CHARGES	217,752.43	CONTRACTUAL ALLOW	109,769.93
NON-COVERD CHARGES	7,398.00	TOTAL MEDICAID LIAB	107,982.50
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	107,982.50

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	58		0	31,371.00		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	58		0	31,371.00		748.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	58		0	31,371.00		748.00

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,789.00	0.00	OTHER LAB	2,916.00	0.00
MED/SURG SUPPLY	13,515.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,493.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,138.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,459.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	197.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,541.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,987.00	0.00	PROFESSIONAL FEES	0.00	5,332.00
OPERATING ROOM	2,060.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,115.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,345.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,322.43	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	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	628.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,458.00	1,318.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,418.00	0.00			
			TOTAL ANCILLARY	186,381.43	6,650.00
			TOTAL ACCOMODATIONS	31,371.00	748.00
			TOTAL CHARGES	217,752.43	7,398.00

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/16	THROUGH	07/31/17
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: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,256,306.76	ADJUSTMENTS	17,211.92
COVERED CHARGES	1,202,391.52	CONTRACTUAL ALLOW	819,274.99
NON-COVERD CHARGES	53,915.24	TOTAL MEDICAID LIAB	383,116.53
		LESS: COB	12,709.75
		LESS: COPAYMENT	795.00
		REIMBURSEMENT	369,611.78
		ALL OTHER	334,394.99
		FEE SCHEDULE-LAB	27,553.85
		INJECTABLE DRUGS	7,662.94

TOTAL NUMBER OF CLAIMS 857

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,681.14	0.00	OTHER LAB	683.00	0.00
MED/SURG SUPPLY	56,963.00	67.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,127.00	2,401.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,065.00	14,244.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,734.00	2,477.00	FEE SCHEDULE LAB	238,595.00	14,356.00
EKG/ECG	30,192.00	478.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,420.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,547.00	4,531.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,379.00	3,127.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,378.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	333,782.00	7,302.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,015.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,831.38	401.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,333.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,716.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,912.00	343.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	149,037.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,345.00	609.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	988.00	482.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	655.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,859.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,525.00	726.00			
			TOTAL ANCILLARY	1,202,391.52	53,915.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,202,391.52	53,915.24

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL
361 RANDOLPH ST
CUTHBERT,GA 39840-6127

PROVIDER NUMBER
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,658.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,598.00	CONTRACTUAL ALLOW	1,473.60
NON-COVERD CHARGES	60.00	TOTAL MEDICAID LIAB	2,124.40
		LESS: COB	2,124.40
		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

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	197.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	440.00	60.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,833.00	0.00	SPECIAL SERVICES	0.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,598.00	60.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,598.00	60.00

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: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,319.72	ADJUSTMENTS	0.00
COVERED CHARGES	54,113.72	CONTRACTUAL ALLOW	51,597.72
NON-COVERD CHARGES	1,206.00	TOTAL MEDICAID LIAB	2,516.00
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	2,453.00
		TOTAL NUMBER OF CLAIMS	51

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,811.72	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	733.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,079.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,822.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,661.00	549.00
EKG/ECG	232.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,455.00	641.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,320.00	16.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	54,113.72	1,206.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,113.72	1,206.00

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: 08/29/2018
Run Time: 00:27:44
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,547.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,484.00	CONTRACTUAL ALLOW	752.04
NON-COVERD CHARGES	63.00	TOTAL MEDICAID LIAB	1,731.96
		LESS: COB	1,731.96
		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

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	255.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	857.00	63.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,289.00	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	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	2,484.00	63.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,484.00	63.00

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

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

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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	08/01/16	THROUGH	07/31/17
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: 08/29/2018
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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	08/01/16	THROUGH	07/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL
 2518 JIMMY LEE SMITH PKWY
 HIRAM,GA 30141-2068

PROVIDER NUMBER 000001438A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,720,540.82	ADJUSTMENTS	158,634.42
COVERED CHARGES	11,673,905.82	CONTRACTUAL ALLOW	9,042,366.14
NON-COVERD CHARGES	46,635.00	TOTAL MEDICAID LIAB	2,631,539.68
		LESS: COB	10,135.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,621,404.18

TOTAL NUMBER OF ADMISSIONS 332

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	700		2	861,000.00		46,600.00
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	700		2	861,000.00		46,600.00
SPECIAL CARE SERVICES						
CCU	450		0	1,084,500.00		0.00
ICU	149		0	513,007.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	599		0	1,597,507.00		0.00
TOTAL ACCOMODATIONS	1,299		2	2,458,507.00		46,600.00

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,083,018.75	0.00	OTHER LAB	119,674.00	0.00
MED/SURG SUPPLY	345,033.91	35.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,849,109.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	298,661.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	971,325.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,965.14	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	155,109.00	0.00	MRI SERVICES	275,127.00	0.00
IV THERAPY	264,875.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	383,683.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,082,680.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	212,461.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	851,947.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	58,614.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	40,890.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,855.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	25,608.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	69,630.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,219.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,798.00	0.00	IMPL DEV CHARGE PATIENTS	66,038.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	75,542.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	150,191.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,620.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	436,513.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,626.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	195,585.35	0.00			
			TOTAL ANCILLARY	9,215,398.82	35.00
			TOTAL ACCOMODATIONS	2,458,507.00	46,600.00
			TOTAL CHARGES	11,673,905.82	46,635.00

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	127,973.75	ADJUSTMENTS	0.00
COVERED CHARGES	127,787.75	CONTRACTUAL ALLOW	68,518.69
NON-COVERD CHARGES	186.00	TOTAL MEDICAID LIAB	59,269.06
		LESS: COB	59,269.06
		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	3		0	3,690.00		186.00
ROUTINE NURSERY	0		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	3,690.00		186.00
SPECIAL CARE SERVICES						
CCU	8		0	19,280.00		0.00
ICU	1		0	3,443.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	22,723.00		0.00
TOTAL ACCOMODATIONS	12		0	26,413.00		186.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,942.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	644.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,833.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,253.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,616.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,788.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,448.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	320.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,780.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	23,952.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,545.00	0.00			
BLOOD	0.00	0.00			
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	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	101,374.75	0.00
			TOTAL ACCOMODATIONS	26,413.00	186.00
			TOTAL CHARGES	127,787.75	186.00

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: 08/29/2018
Run Time: 00:07:39
Page: 5

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,788,657.39	ADJUSTMENTS	173,274.98
COVERED CHARGES	12,957,421.09	CONTRACTUAL ALLOW	11,319,439.34
NON-COVERD CHARGES	831,236.30	TOTAL MEDICAID LIAB	1,637,981.75
		LESS: COB	29,395.16
		LESS: COPAYMENT	2,442.00
		REIMBURSEMENT	1,606,144.59
		ALL OTHER	1,496,191.08
		FEE SCHEDULE-LAB	94,526.48
		INJECTABLE DRUGS	15,427.03

TOTAL NUMBER OF CLAIMS 3,106

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	341,310.25	6,217.00	OTHER LAB	219,465.00	0.00
MED/SURG SUPPLY	136,256.92	9,517.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	844,621.00	6,650.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,200,145.00	220,352.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,886.00	11,988.02	FEE SCHEDULE LAB	1,795,372.00	62,457.00
EKG/ECG	241,274.00	2,235.00	MRI SERVICES	542,158.00	53,001.00
IV THERAPY	761,725.00	4,187.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	382,510.00	48,859.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65,600.00	65,185.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	245,578.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,288,416.00	1,898.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	121,110.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	138,556.25	58,188.00
RADIOLOGY THERAPEUTIC	578,156.00	99,738.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	382.00	382.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,875.00	2,732.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,976.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,372.00	6,230.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	25,397.00	52,208.00	IMPL DEV CHARGE PATIENTS	34,722.20	15,151.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	267,030.00	42,000.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,278.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	183,964.00	19,709.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	160,935.00	26,217.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	183,424.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,902.47	4,158.00			
			TOTAL ANCILLARY	12,957,421.09	831,236.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,957,421.09	831,236.30

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	298,819.07	ADJUSTMENTS	0.00
COVERED CHARGES	264,002.14	CONTRACTUAL ALLOW	139,671.41
NON-COVERD CHARGES	34,816.93	TOTAL MEDICAID LIAB	124,330.73
		LESS: COB	124,303.73
		LESS: COPAYMENT	27.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,268.75	555.00	OTHER LAB	3,168.00	0.00
MED/SURG SUPPLY	4,954.24	98.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,247.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,962.00	10,446.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	46,850.00	912.00
EKG/ECG	4,023.00	0.00	MRI SERVICES	0.00	9,062.00
IV THERAPY	19,292.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,171.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	2,419.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,688.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	102,913.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	218.25	1,857.25
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	977.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,564.00	IMPL DEV CHARGE PATIENTS	0.00	943.68
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,322.00	5,392.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,038.00	480.00			
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	7,305.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,866.90	0.00			
			TOTAL ANCILLARY	264,002.14	34,816.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	264,002.14	34,816.93

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	627,247.50	ADJUSTMENTS	217.76
COVERED CHARGES	597,760.50	CONTRACTUAL ALLOW	580,831.31
NON-COVERD CHARGES	29,487.00	TOTAL MEDICAID LIAB	16,929.19
		LESS: COB	959.95
		LESS: COPAYMENT	420.00
		REIMBURSEMENT	15,549.24
		TOTAL NUMBER OF CLAIMS	286

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,232.25	0.00	OTHER LAB	22,028.00	0.00
MED/SURG SUPPLY	481.00	339.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,631.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,655.00	13,148.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	116,816.00	5,410.00
EKG/ECG	11,622.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,677.00	185.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	293,749.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.25	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	2,776.00	6,143.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,460.00	4,234.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	597,760.50	29,487.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	597,760.50	29,487.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,968.50	ADJUSTMENTS	0.00
COVERED CHARGES	34,620.50	CONTRACTUAL ALLOW	22,139.59
NON-COVERD CHARGES	1,348.00	TOTAL MEDICAID LIAB	12,480.91
		LESS: COB	12,456.91
		LESS: COPAYMENT	24.00
		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
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL
 2518 JIMMY LEE SMITH PKWY
 HIRAM,GA 30141-2068

PROVIDER NUMBER
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	895.50	0.00	OTHER LAB	3,168.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,502.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,882.00	0.00
EKG/ECG	894.00	0.00	MRI SERVICES	3,970.00	0.00
IV THERAPY	1,880.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,429.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,348.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,620.50	1,348.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,620.50	1,348.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	503,851.31	ADJUSTMENTS	10,899.60
COVERED CHARGES	503,377.31	CONTRACTUAL ALLOW	454,234.61
NON-COVERD CHARGES	474.00	TOTAL MEDICAID LIAB	49,142.70
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	48,923.70

TOTAL NUMBER OF CLAIMS 9

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,267.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,586.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,611.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,903.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,450.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,384.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	184,827.25	0.00
RADIOLOGY THERAPEUTIC	254,902.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,219.00	474.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,951.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	503,377.31	474.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	503,377.31	474.00

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:50:44
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	672,023.16	ADJUSTMENTS	89,258.30
COVERED CHARGES	669,663.16	CONTRACTUAL ALLOW	362,035.15
NON-COVERD CHARGES	2,360.00	TOTAL MEDICAID LIAB	307,628.01
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	307,628.01

TOTAL NUMBER OF ADMISSIONS 64

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	199		0	138,305.00		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	199		0	138,305.00		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	199		0	138,305.00		0.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142,086.44	0.00	OTHER LAB	1,845.00	0.00
MED/SURG SUPPLY	18,866.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	103,151.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,889.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,793.00	1,923.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	775.05	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,994.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	26,280.00	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	29,100.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,228.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71,802.17	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	437.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	369.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,714.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,896.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,706.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,870.00	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	1,993.00	0.00			
			TOTAL ANCILLARY	531,358.16	2,360.00
			TOTAL ACCOMODATIONS	138,305.00	0.00
			TOTAL CHARGES	669,663.16	2,360.00

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

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

Run Date: 08/29/2018
 Run Time: 00:50:44
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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.
 1960 HIGHWAY 247 CONNECTOR
 BYRON,GA 31008-5663

PROVIDER NUMBER 000001449A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,304.90	ADJUSTMENTS	0.00
COVERED CHARGES	8,304.90	CONTRACTUAL ALLOW	3,286.14
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,018.76
		LESS: COB	5,018.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,780.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	2,780.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	4		0	2,780.00		0.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,440.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	738.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	189.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	272.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,278.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	628.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	979.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	5,524.90	0.00
			TOTAL ACCOMODATIONS	2,780.00	0.00
			TOTAL CHARGES	8,304.90	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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,784,974.13	ADJUSTMENTS	111,060.91
COVERED CHARGES	2,551,965.12	CONTRACTUAL ALLOW	1,798,062.56
NON-COVERD CHARGES	233,009.01	TOTAL MEDICAID LIAB	753,902.56
		LESS: COB	7,350.46
		LESS: COPAYMENT	1,368.00
		REIMBURSEMENT	745,184.10
		ALL OTHER	659,298.99
		FEE SCHEDULE-LAB	81,098.34
		INJECTABLE DRUGS	4,786.77

TOTAL NUMBER OF CLAIMS 1,961

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	174,503.21	864.20	OTHER LAB	260,763.00	0.00
MED/SURG SUPPLY	21,491.00	3,098.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110,891.00	24,457.00	OTHER THERAPEUTIC SVC	0.00	504.00
CT SCAN	358,808.00	51,075.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,511.00	2,954.00	FEE SCHEDULE LAB	624,541.00	18,939.00
EKG/ECG	25,530.00	666.00	MRI SERVICES	7,888.00	3,454.00
IV THERAPY	179,137.00	6,696.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	69,435.50	93,109.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,130.00	6,805.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,432.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	481,331.00	1,580.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,774.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,000.41	8,763.29
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,163.00	387.02	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	2,092.00	35.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,226.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	56,387.00	6,858.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,754.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,706.00	251.00			
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	19,836.00	0.00			
			TOTAL ANCILLARY	2,551,965.12	233,009.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,551,965.12	233,009.01

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

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

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

THE MEDICAL CENTER OF PEACH COUNTY, INC.
1960 HIGHWAY 247 CONNECTOR
BYRON,GA 31008-5663

PROVIDER NUMBER
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,461.14	ADJUSTMENTS	0.00
COVERED CHARGES	13,450.25	CONTRACTUAL ALLOW	7,122.12
NON-COVERD CHARGES	2,010.89	TOTAL MEDICAID LIAB	6,328.13
		LESS: COB	6,320.13
		LESS: COPAYMENT	8.00
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	591.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,227.00	285.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,058.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,428.00	604.00
EKG/ECG	111.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	805.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136.00	53.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,307.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	844.68	10.89
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,450.25	2,010.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,450.25	2,010.89

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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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	111,754.83	ADJUSTMENTS	141.00
COVERED CHARGES	99,959.34	CONTRACTUAL ALLOW	92,759.34
NON-COVERD CHARGES	11,795.49	TOTAL MEDICAID LIAB	7,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	6,888.00
		TOTAL NUMBER OF CLAIMS	144

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,793.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	328.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,199.00	775.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,366.00	9,529.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,991.00	535.00
EKG/ECG	555.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,049.00	248.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136.00	373.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,650.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,891.54	335.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	99,959.34	11,795.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	99,959.34	11,795.49

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

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

Run Date: 08/29/2018
Run Time: 00:50:50
Page: 11

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,361.03	ADJUSTMENTS	0.00
COVERED CHARGES	4,246.03	CONTRACTUAL ALLOW	3,122.68
NON-COVERD CHARGES	1,115.00	TOTAL MEDICAID LIAB	1,123.35
		LESS: COB	1,117.35
		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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	430.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,058.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,283.00	57.00
EKG/ECG	111.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	124.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,298.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,246.03	1,115.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,246.03	1,115.00

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	97,469.90	ADJUSTMENTS	9,722.78
COVERED CHARGES	92,427.87	CONTRACTUAL ALLOW	77,839.20
NON-COVERD CHARGES	5,042.03	TOTAL MEDICAID LIAB	14,588.67
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	14,582.67

TOTAL NUMBER OF CLAIMS 3

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,465.31	0.00	OTHER LAB	337.00	0.00
MED/SURG SUPPLY	4,480.00	358.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	114.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,664.00	3,011.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	195.00	0.03	FEE SCHEDULE LAB	2,669.00	57.00
EKG/ECG	111.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,138.00	868.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,328.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,001.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,732.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,046.56	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	10,681.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	634.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,580.00	0.00			
			TOTAL ANCILLARY	92,427.87	5,042.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,427.87	5,042.03

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

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

Run Date: 08/29/2018
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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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER 000001471A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,173,056.24	ADJUSTMENTS	70,455.36
COVERED CHARGES	1,150,649.39	CONTRACTUAL ALLOW	741,475.00
NON-COVERD CHARGES	22,406.85	TOTAL MEDICAID LIAB	409,174.39
		LESS: COB	3,497.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	405,676.78

TOTAL NUMBER OF ADMISSIONS 44

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	167		0	162,825.00		22,140.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	167		0	162,825.00		22,140.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	92		0	230,000.00		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	92		0	230,000.00		0.00
TOTAL ACCOMODATIONS	259		0	392,825.00		22,140.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,923.32	0.00	OTHER LAB	3,477.72	0.00
MED/SURG SUPPLY	17,378.57	203.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	84,293.88	63.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,321.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,000.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,024.91	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,052.00	0.00	MRI SERVICES	4,000.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	160,906.78	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,134.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,050.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	114,548.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,002.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,985.81	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	229.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	39,275.32	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,894.32	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,319.66	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	932.78	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,067.12	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	9,007.00	0.00			
			TOTAL ANCILLARY	757,824.39	266.85
			TOTAL ACCOMODATIONS	392,825.00	22,140.00
			TOTAL CHARGES	1,150,649.39	22,406.85

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

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

Run Date: 08/29/2018
 Run Time: 00:41:25
 Page: 3

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,944.10	ADJUSTMENTS	0.00
COVERED CHARGES	17,884.70	CONTRACTUAL ALLOW	7,072.14
NON-COVERD CHARGES	59.40	TOTAL MEDICAID LIAB	10,812.56
		LESS: COB	10,812.56
		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	5		0	4,875.00		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	5		0	4,875.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	4,875.00		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	377.38	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,660.13	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	167.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,750.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	782.43	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	59.40
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	330.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,132.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	315.72	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,133.39	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	765.00	0.00			
			TOTAL ANCILLARY	13,009.70	59.40
			TOTAL ACCOMODATIONS	4,875.00	0.00
			TOTAL CHARGES	17,884.70	59.40

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: 08/29/2018
Run Time: 00:41:25
Page: 5

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,294,353.34	ADJUSTMENTS	41,760.12
COVERED CHARGES	2,175,261.93	CONTRACTUAL ALLOW	1,780,043.45
NON-COVERD CHARGES	119,091.41	TOTAL MEDICAID LIAB	395,218.48
		LESS: COB	1,636.75
		LESS: COPAYMENT	872.52
		REIMBURSEMENT	392,709.21
		ALL OTHER	341,597.77
		FEE SCHEDULE-LAB	45,353.18
		INJECTABLE DRUGS	5,758.26
		TOTAL NUMBER OF CLAIMS	1,191

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,388.59	67.51	OTHER LAB	54,870.76	0.00
MED/SURG SUPPLY	15,340.59	283.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,896.44	4,928.06	OTHER THERAPEUTIC SVC	0.00	199.20
CT SCAN	92,500.00	3,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	151,783.50	10,294.74
EKG/ECG	43,473.00	0.00	MRI SERVICES	22,000.00	1,000.00
IV THERAPY	58,659.00	5,535.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	168,556.88	60,310.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,335.50	2,814.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,650.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,313,409.25	3,922.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,562.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,050.80	20,490.53
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	373.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,029.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,540.96	3,106.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,040.80	882.57			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,667.80	1,133.39			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,375.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,131.29	0.00			
			TOTAL ANCILLARY	2,175,261.93	119,091.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,175,261.93	119,091.41

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: 08/29/2018
Run Time: 00:41:25
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
-1	2317069000020	02/15/17 - 01/01/00	03/27/17	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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

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

Run Date: 08/29/2018
Run Time: 00:41:29
Page: 8

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,721.57	ADJUSTMENTS	0.00
COVERED CHARGES	19,465.98	CONTRACTUAL ALLOW	9,645.76
NON-COVERD CHARGES	1,255.59	TOTAL MEDICAID LIAB	9,820.22
		LESS: COB	9,808.27
		LESS: COPAYMENT	11.95
		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

PERRY HOSPITAL
 1120 MORNINGSIDE DR
 PERRY,GA 31069-2906

PROVIDER NUMBER
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	68.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	335.30	0.00	OTHER THERAPEUTIC SVC	0.00	498.00
CT SCAN	0.00	750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	183.96	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,844.50	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	7.42	7.59
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,465.98	1,255.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,465.98	1,255.59

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

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

Run Date: 08/29/2018
Run Time: 00:41:29
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,416.48	ADJUSTMENTS	55.94
COVERED CHARGES	69,095.40	CONTRACTUAL ALLOW	66,969.68
NON-COVERD CHARGES	321.08	TOTAL MEDICAID LIAB	2,125.72
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	2,062.72
		TOTAL NUMBER OF CLAIMS	38

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	670.60	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	1,600.26	85.32
EKG/ECG	298.00	0.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,628.50	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	217.54	235.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	69,095.40	321.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	69,095.40	321.08

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,341.96	ADJUSTMENTS	0.00
COVERED CHARGES	7,582.96	CONTRACTUAL ALLOW	5,220.37
NON-COVERD CHARGES	759.00	TOTAL MEDICAID LIAB	2,362.59
		LESS: COB	2,359.59
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	167.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	208.98	9.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,197.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.33	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	7,582.96	759.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,582.96	759.00

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,475.99	ADJUSTMENTS	0.00
COVERED CHARGES	23,647.53	CONTRACTUAL ALLOW	18,371.19
NON-COVERD CHARGES	828.46	TOTAL MEDICAID LIAB	5,276.34
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,276.34

TOTAL NUMBER OF CLAIMS 1

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21.00	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	167.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	795.12	57.63
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	522.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	184.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,259.26	20.83
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,647.53	828.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,647.53	828.46

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL
1120 MORNINGSIDE DR
PERRY,GA 31069-2906

PROVIDER NUMBER
000001471A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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

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

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT 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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,775,989.77	ADJUSTMENTS	149,513.62
COVERED CHARGES	7,533,682.77	CONTRACTUAL ALLOW	5,541,391.98
NON-COVERD CHARGES	242,307.00	TOTAL MEDICAID LIAB	1,992,290.79
		LESS: COB	24,549.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,967,741.34

TOTAL NUMBER OF ADMISSIONS 265

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	776		4	820,013.00		169,158.00
ROUTINE NURSERY	56		0	50,670.00		376.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	832		4	870,683.00		169,534.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	138		0	503,044.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	138		0	503,044.00		0.00
TOTAL ACCOMODATIONS	970		4	1,373,727.00		169,534.00

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,003,043.57	0.00	OTHER LAB	95,808.00	0.00
MED/SURG SUPPLY	107,407.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,130,700.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	149,256.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	840,326.00	4,748.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	55,706.19	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	95,642.00	0.00	MRI SERVICES	79,692.00	0.00
IV THERAPY	13,000.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	353,069.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	123,075.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	537,872.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,292.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	36,180.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	716,359.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	102,495.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,611.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,044.68	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,346.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	147,254.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	58,019.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	97,852.00	66,192.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,695.00	1,833.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	227,935.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	83,274.80	0.00			
			TOTAL ANCILLARY	6,159,955.77	72,773.00
			TOTAL ACCOMODATIONS	1,373,727.00	169,534.00
			TOTAL CHARGES	7,533,682.77	242,307.00

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

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,715,243.81	ADJUSTMENTS	248,951.95
COVERED CHARGES	11,757,730.72	CONTRACTUAL ALLOW	10,300,712.73
NON-COVERD CHARGES	1,957,513.09	TOTAL MEDICAID LIAB	1,457,017.99
		LESS: COB	15,365.43
		LESS: COPAYMENT	2,827.37
		REIMBURSEMENT	1,438,825.19
		ALL OTHER	1,323,454.60
		FEE SCHEDULE-LAB	97,923.45
		INJECTABLE DRUGS	17,447.14
		TOTAL NUMBER OF CLAIMS	2,944

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	190,551.86	0.00	OTHER LAB	191,067.00	2,152.00
MED/SURG SUPPLY	197,740.97	13,516.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	565,090.00	44,188.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,368,223.00	542,798.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,790.04	FEE SCHEDULE LAB	1,457,665.00	70,807.00
EKG/ECG	188,819.00	10,353.00	MRI SERVICES	417,772.00	66,952.00
IV THERAPY	62,763.00	6,223.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	755,744.00	275,948.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	45,753.00	0.00	REHAB THERAPY	0.00	504.00
RESPIRATORY SERVICES	73,736.00	13,788.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	136,922.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	192,137.00	67,174.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,129,923.00	152,105.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	315,084.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	196,829.44	302,558.87
RADIOLOGY THERAPEUTIC	3,597.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,206.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	39,332.00	7,362.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,505.95	62,783.21
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	433,617.00	65,870.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	52,207.00	31,520.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	152,339.00	127,380.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	249,011.00	76,554.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	141,039.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	172,262.50	8,980.00			
			TOTAL ANCILLARY	11,757,730.72	1,957,513.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,757,730.72	1,957,513.09

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	181,375.83	ADJUSTMENTS	0.00
COVERED CHARGES	112,671.29	CONTRACTUAL ALLOW	62,696.33
NON-COVERD CHARGES	68,704.54	TOTAL MEDICAID LIAB	49,974.96
		LESS: COB	49,960.88
		LESS: COPAYMENT	14.08
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,523.21	0.00	OTHER LAB	3,019.00	0.00
MED/SURG SUPPLY	734.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,329.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,005.00	38,076.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,404.00	627.00
EKG/ECG	1,972.00	0.00	MRI SERVICES	9,885.00	14,230.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,156.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,622.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	972.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,611.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,205.00	347.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,547.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,878.50	1,781.20
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	436.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	99.34
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	11,386.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,158.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,371.60	0.00			
			TOTAL ANCILLARY	112,671.29	68,704.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	112,671.29	68,704.54

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

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	295,301.07	ADJUSTMENTS	317.38
COVERED CHARGES	277,785.89	CONTRACTUAL ALLOW	269,957.16
NON-COVERD CHARGES	17,515.18	TOTAL MEDICAID LIAB	7,828.73
		LESS: COB	948.11
		LESS: COPAYMENT	230.10
		REIMBURSEMENT	6,650.52
		TOTAL NUMBER OF CLAIMS	123

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,178.68	0.00	OTHER LAB	1,698.00	0.00
MED/SURG SUPPLY	230.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,429.00	2,119.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,889.00	9,542.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,782.00	2,009.00
EKG/ECG	2,465.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146,665.00	1,281.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,474.61	1,122.18
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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,537.00	1,442.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,898.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,431.60	0.00			
			TOTAL ANCILLARY	277,785.89	17,515.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	277,785.89	17,515.18

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,214.49	ADJUSTMENTS	0.00
COVERED CHARGES	2,214.49	CONTRACTUAL ALLOW	1,340.85
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	873.64
		LESS: COB	867.64
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	299.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,848.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,214.49	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,214.49	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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	140,937.01	ADJUSTMENTS	5,434.60
COVERED CHARGES	139,192.68	CONTRACTUAL ALLOW	122,870.88
NON-COVERD CHARGES	1,744.33	TOTAL MEDICAID LIAB	16,321.80
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	16,303.80

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,489.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,141.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	583.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,168.00	0.00
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	57,566.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,855.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,087.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,804.55	1,744.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,605.12	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,374.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,918.00	0.00			
			TOTAL ANCILLARY	139,192.68	1,744.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	139,192.68	1,744.33

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VIII

Run Date: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,834.50	ADJUSTMENTS	0.00
COVERED CHARGES	74,284.50	CONTRACTUAL ALLOW	51,551.03
NON-COVERD CHARGES	550.00	TOTAL MEDICAID LIAB	22,733.47
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	22,733.47

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		0	6,600.00		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	12		0	6,600.00		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	12		0	6,600.00		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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,720.00	0.00	OTHER LAB	716.00	0.00
MED/SURG SUPPLY	4,451.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,315.00	0.00	EDUCATION & TRAINING	64.00	0.00
RADIOLOGY-DIAGNOSTIC	920.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,950.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,011.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,096.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,316.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,661.50	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	49.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,415.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	550.00			
			TOTAL ANCILLARY	67,684.50	550.00
			TOTAL ACCOMODATIONS	6,600.00	0.00
			TOTAL CHARGES	74,284.50	550.00

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

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,877,589.14	ADJUSTMENTS	122,864.11
COVERED CHARGES	6,702,311.64	CONTRACTUAL ALLOW	5,606,221.89
NON-COVERD CHARGES	175,277.50	TOTAL MEDICAID LIAB	1,096,089.75
		LESS: COB	15.75
		LESS: COPAYMENT	824.10
		REIMBURSEMENT	1,095,249.90
		ALL OTHER	991,808.18
		FEE SCHEDULE-LAB	87,079.02
		INJECTABLE DRUGS	16,362.70
		TOTAL NUMBER OF CLAIMS	2,535

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,893.50	0.00	OTHER LAB	17,895.00	0.00
MED/SURG SUPPLY	258,963.64	5,375.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	788.00	64.00
RADIOLOGY-DIAGNOSTIC	317,609.00	12,329.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	664,919.00	1,840.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,252,456.00	50,040.00
EKG/ECG	97,039.00	337.00	MRI SERVICES	11,963.00	1,548.00
IV THERAPY	54,023.00	7,342.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,391.00	140.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,698.00	33,281.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,336.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,402,091.00	31,915.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,956.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	323,725.50	13,849.50
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	19,730.00	864.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,014.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,447.00	1,312.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	592.00	550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,476.00	8,077.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	99,306.00	6,414.00			
			TOTAL ANCILLARY	6,702,311.64	175,277.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,702,311.64	175,277.50

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,669.00	ADJUSTMENTS	0.00
COVERED CHARGES	54,408.00	CONTRACTUAL ALLOW	34,119.19
NON-COVERD CHARGES	2,261.00	TOTAL MEDICAID LIAB	20,288.81
		LESS: COB	20,273.81
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.00	0.00	OTHER LAB	716.00	0.00
MED/SURG SUPPLY	1,664.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	996.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,353.00	1,801.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,979.00	290.00
EKG/ECG	337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,484.00	170.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,320.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	950.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	375.00	0.00			
			TOTAL ANCILLARY	54,408.00	2,261.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,408.00	2,261.00

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: 08/29/2018
Run Time: 00:53:52
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	333,553.89	ADJUSTMENTS	1,093.00
COVERED CHARGES	326,113.89	CONTRACTUAL ALLOW	318,113.89
NON-COVERD CHARGES	7,440.00	TOTAL MEDICAID LIAB	8,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	267.71
		REIMBURSEMENT	7,732.29
		TOTAL NUMBER OF CLAIMS	160

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,154.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,957.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,841.00	642.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,049.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	44,125.00	1,326.00
EKG/ECG	2,022.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	208,564.00	4,549.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,941.25	143.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	470.00	610.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,711.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,120.00	170.00			
			TOTAL ANCILLARY	326,113.89	7,440.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	326,113.89	7,440.00

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,074.50	ADJUSTMENTS	0.00
COVERED CHARGES	5,074.50	CONTRACTUAL ALLOW	4,469.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	605.01
		LESS: COB	596.01
		LESS: COPAYMENT	9.00
		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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	162.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	385.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	4,281.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	246.50	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	5,074.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,074.50	0.00

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

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,790.75	ADJUSTMENTS	4,862.89
COVERED CHARGES	94,480.75	CONTRACTUAL ALLOW	79,892.08
NON-COVERD CHARGES	1,310.00	TOTAL MEDICAID LIAB	14,588.67
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	14,561.67

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,770.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,935.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	205.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,264.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,167.00	105.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,017.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,335.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,603.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,016.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	489.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,821.50	1,205.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,410.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,448.00	0.00			
			TOTAL ANCILLARY	94,480.75	1,310.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	94,480.75	1,310.00

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL
 101 LAKE OCONEE PARKWAY
 EATONTON,GA 31024-6054

PROVIDER NUMBER 000001537A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	206,794.75	ADJUSTMENTS	9,100.88
COVERED CHARGES	205,057.46	CONTRACTUAL ALLOW	83,774.78
NON-COVERD CHARGES	1,737.29	TOTAL MEDICAID LIAB	121,282.68
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	121,282.68

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	72		0	25,200.00		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	25,200.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	25		0	16,875.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	16,875.00		0.00
TOTAL ACCOMODATIONS	97		0	42,075.00		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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,220.90	0.00	OTHER LAB	915.88	0.00
MED/SURG SUPPLY	17,847.02	110.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	36,205.08	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,930.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,117.78	1,423.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	793.54	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,172.43	0.00	MRI SERVICES	2,168.73	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,032.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,288.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,613.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	377.07	203.53			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,300.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	162,982.46	1,737.29
			TOTAL ACCOMODATIONS	42,075.00	0.00
			TOTAL CHARGES	205,057.46	1,737.29

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	685,637.59	ADJUSTMENTS	11,712.90
COVERED CHARGES	577,411.19	CONTRACTUAL ALLOW	350,235.92
NON-COVERD CHARGES	108,226.40	TOTAL MEDICAID LIAB	227,175.27
		LESS: COB	582.04
		LESS: COPAYMENT	561.00
		REIMBURSEMENT	226,032.23
		ALL OTHER	205,667.32
		FEE SCHEDULE-LAB	19,234.68
		INJECTABLE DRUGS	1,130.23

TOTAL NUMBER OF CLAIMS 620

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,668.10	822.40	OTHER LAB	19,848.33	0.00
MED/SURG SUPPLY	34,770.79	900.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,495.77	3,409.61	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	80,355.29	43,037.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	746.53	1,064.84	FEE SCHEDULE LAB	99,506.22	6,351.24
EKG/ECG	8,388.50	161.54	MRI SERVICES	19,143.19	5,221.09
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,756.19	3,854.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,120.93	814.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,252.92	7,046.60	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	159,205.94	3,780.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,375.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,712.00	2,511.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	165.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	457.15	88.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,390.15	1,258.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,706.97	610.59			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,020.00	24,554.44			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,170.00	650.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,155.83	2,089.55			
			TOTAL ANCILLARY	577,411.19	108,226.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	577,411.19	108,226.40

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,221.16	ADJUSTMENTS	0.00
COVERED CHARGES	2,162.79	CONTRACTUAL ALLOW	1,173.81
NON-COVERD CHARGES	58.37	TOTAL MEDICAID LIAB	988.98
		LESS: COB	988.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	77.99	41.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	334.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	533.88	17.14
EKG/ECG	72.41	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,041.92	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,162.79	58.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,162.79	58.37

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

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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,830.63	ADJUSTMENTS	47.00
COVERED CHARGES	29,382.30	CONTRACTUAL ALLOW	27,180.29
NON-COVERD CHARGES	448.33	TOTAL MEDICAID LIAB	2,202.01
		LESS: COB	0.00
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	2,094.01
		TOTAL NUMBER OF CLAIMS	48

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	660.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	469.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	425.28	128.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,668.22	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,548.96	166.78
EKG/ECG	144.82	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,568.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	852.00	153.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	29,382.30	448.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,382.30	448.33

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
101 LAKE OCONEE PARKWAY
EATONTON,GA 31024-6054

PROVIDER NUMBER
000001537A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,607.07	ADJUSTMENTS	0.00
COVERED CHARGES	1,380.81	CONTRACTUAL ALLOW	1,242.74
NON-COVERD CHARGES	226.26	TOTAL MEDICAID LIAB	138.07
		LESS: COB	138.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PUTNAM GENERAL HOSPITAL
 101 LAKE OCONEE PARKWAY
 EATONTON,GA 31024-6054

PROVIDER NUMBER
 000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	171.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	222.83	17.14
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	89.12	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	458.20	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	60.00	120.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	360.61	0.00			
			TOTAL ANCILLARY	1,380.81	226.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,380.81	226.26

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,401.43	ADJUSTMENTS	4,859.89
COVERED CHARGES	15,220.77	CONTRACTUAL ALLOW	10,357.88
NON-COVERD CHARGES	3,180.66	TOTAL MEDICAID LIAB	4,862.89
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,859.89

TOTAL NUMBER OF CLAIMS 1

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,305.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,670.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	122.55	17.14
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,303.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	2,690.52	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	430.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	390.00	473.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,220.77	3,180.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,220.77	3,180.66

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

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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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

TAYLOR REGIONAL HOSPITAL
 222 PERRY HWY
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER 000001548A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,375,103.94	ADJUSTMENTS	29,889.60
COVERED CHARGES	1,361,979.94	CONTRACTUAL ALLOW	513,340.96
NON-COVERD CHARGES	13,124.00	TOTAL MEDICAID LIAB	848,638.98
		LESS: COB	11,969.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	836,669.97

TOTAL NUMBER OF ADMISSIONS 119

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	254		0	132,080.00		7,515.00
ROUTINE NURSERY	24		0	11,980.00		210.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	278		0	144,060.00		7,725.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	94		0	121,891.00		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	94		0	121,891.00		0.00
TOTAL ACCOMODATIONS	372		0	265,951.00		7,725.00

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	175,085.40	0.00	OTHER LAB	2,168.50	0.00
MED/SURG SUPPLY	90,987.98	84.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	159,904.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,306.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,817.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,220.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,572.00	0.00	MRI SERVICES	14,568.00	0.00
IV THERAPY	436.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	122,889.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,929.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,854.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	43,946.00	0.00	AMBULANCE	0.00	1,125.00
GI SERVICES	11,822.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,912.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,484.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,261.60	0.00	INJECTABLE DRUGS	113,645.50	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	440.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	110.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	40,792.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,965.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,860.00	4,074.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,016.50	115.50			
AUDIOLOGY	2,047.50	0.00			
CARDIOLOGY	24,871.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,115.19	0.00			
			TOTAL ANCILLARY	1,096,028.94	5,399.00
			TOTAL ACCOMODATIONS	265,951.00	7,725.00
			TOTAL CHARGES	1,361,979.94	13,124.00

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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	03/31/17
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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,995,767.71	ADJUSTMENTS	37,517.20
COVERED CHARGES	1,908,271.21	CONTRACTUAL ALLOW	1,461,091.36
NON-COVERD CHARGES	87,496.50	TOTAL MEDICAID LIAB	447,179.85
		LESS: COB	852.38
		LESS: COPAYMENT	1,362.00
		REIMBURSEMENT	444,965.47
		ALL OTHER	377,149.15
		FEE SCHEDULE-LAB	59,020.39
		INJECTABLE DRUGS	8,795.93
		TOTAL NUMBER OF CLAIMS	1,801

TAYLOR REGIONAL HOSPITAL
 222 PERRY HWY
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,348.30	5,192.00	OTHER LAB	66,784.50	0.00
MED/SURG SUPPLY	74,698.45	662.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	81.50	EDUCATION & TRAINING	0.00	1.00
RADIOLOGY-DIAGNOSTIC	93,980.50	611.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,059.50	19,111.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,314.50	2,857.50	FEE SCHEDULE LAB	338,404.14	7,662.00
EKG/ECG	20,685.00	1,389.00	MRI SERVICES	53,003.50	2,795.00
IV THERAPY	9,835.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	265,880.50	5,728.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,664.00	424.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,997.50	969.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	75,465.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	40,419.00	100.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	302,593.06	2,421.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,490.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52,717.00	12,020.50
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	140.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,149.50	432.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	970.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	76,708.50	4,026.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,299.50	2,361.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,940.97	11,278.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	51,278.00	3,927.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	42,414.79	2,475.00			
			TOTAL ANCILLARY	1,908,271.21	87,496.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,908,271.21	87,496.50

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,447.75	ADJUSTMENTS	0.00
COVERED CHARGES	13,217.75	CONTRACTUAL ALLOW	4,291.39
NON-COVERD CHARGES	6,230.00	TOTAL MEDICAID LIAB	8,926.36
		LESS: COB	8,923.36
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,153.50	191.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	628.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	682.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,760.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,599.50	136.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	148.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,899.50	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	1,038.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,947.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	330.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	80.00	160.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	406.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	154.00	82.50			
			TOTAL ANCILLARY	13,217.75	6,230.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,217.75	6,230.00

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

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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,437.25	ADJUSTMENTS	317.64
COVERED CHARGES	86,496.75	CONTRACTUAL ALLOW	79,349.28
NON-COVERD CHARGES	2,940.50	TOTAL MEDICAID LIAB	7,147.47
		LESS: COB	0.00
		LESS: COPAYMENT	288.42
		REIMBURSEMENT	6,859.05
		TOTAL NUMBER OF CLAIMS	131

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

TAYLOR REGIONAL HOSPITAL
 222 PERRY HWY
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,039.50	205.00	OTHER LAB	474.50	0.00
MED/SURG SUPPLY	687.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,251.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,181.00	1,645.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,545.00	206.00
EKG/ECG	792.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	533.50	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	46,974.50	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	2,353.00	834.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	665.50	0.00			
			TOTAL ANCILLARY	86,496.75	2,940.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	86,496.75	2,940.50

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,230.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,213.00	CONTRACTUAL ALLOW	1,557.31
NON-COVERD CHARGES	17.00	TOTAL MEDICAID LIAB	655.69
		LESS: COB	649.69
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 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	246.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	421.50	17.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,545.50	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	2,213.00	17.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,213.00	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

TAYLOR REGIONAL HOSPITAL
222 PERRY HWY
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER
000001548A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/16	THROUGH	03/31/17
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: 08/29/2018
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Page: 13

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	04/01/16	THROUGH	03/31/17
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: 08/29/2018
 Run Time: 00:54:56
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 162 LEGACY POINT
 CLAYTON,GA 30525-0705

PROVIDER NUMBER 000001559A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	392,573.15	ADJUSTMENTS	12,657.12
COVERED CHARGES	379,915.35	CONTRACTUAL ALLOW	263,620.42
NON-COVERD CHARGES	12,657.80	TOTAL MEDICAID LIAB	116,294.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	116,294.93

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	67		9	43,675.00		10,900.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		9	43,675.00		10,900.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	67		9	43,675.00		10,900.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 162 LEGACY POINT
 CLAYTON, GA 30525-0705

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,474.51	0.00	OTHER LAB	1,887.00	0.00
MED/SURG SUPPLY	23,089.28	478.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	69,025.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,347.00	1,279.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	324.73	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,066.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	26,395.54	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,687.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,120.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,593.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	435.46	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,254.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,986.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,370.90	0.00			
			TOTAL ANCILLARY	336,240.35	1,757.80
			TOTAL ACCOMODATIONS	43,675.00	10,900.00
			TOTAL CHARGES	379,915.35	12,657.80

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

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

Run Date: 08/29/2018
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
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: 08/29/2018
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	759,050.47	ADJUSTMENTS	85,513.90
COVERED CHARGES	608,103.15	CONTRACTUAL ALLOW	422,744.92
NON-COVERD CHARGES	150,947.32	TOTAL MEDICAID LIAB	185,358.23
		LESS: COB	410.68
		LESS: COPAYMENT	639.00
		REIMBURSEMENT	184,308.55
		ALL OTHER	165,893.19
		FEE SCHEDULE-LAB	16,477.93
		INJECTABLE DRUGS	1,937.43

TOTAL NUMBER OF CLAIMS 553

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 162 LEGACY POINT
 CLAYTON,GA 30525-0705

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,665.03	5,326.40	OTHER LAB	2,340.00	0.00
MED/SURG SUPPLY	45,195.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,085.00	2,724.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,149.00	61,105.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	142,585.00	11,983.00
EKG/ECG	10,220.00	2,190.00	MRI SERVICES	2,161.00	0.00
IV THERAPY	69,584.18	4,973.48	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,000.00	9,616.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,128.00	1,090.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	95,716.00	10,502.00	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	29,420.66	19,753.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,872.00
OTHER IMAGING SERVICE	7,140.00	739.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,324.00	580.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,690.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,389.80	14,803.00			
			TOTAL ANCILLARY	608,103.15	150,947.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	608,103.15	150,947.32

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

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

Run Date: 08/29/2018
Run Time: 00:54:57
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5917341000619	11/29/17 - 11/29/17	12/11/17	0.00	1,872.00	0.00	0.00	0.00
TOTAL				0.00	1,872.00	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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,161.76	ADJUSTMENTS	0.00
COVERED CHARGES	632.00	CONTRACTUAL ALLOW	205.62
NON-COVERD CHARGES	1,529.76	TOTAL MEDICAID LIAB	426.38
		LESS: COB	423.46
		LESS: COPAYMENT	2.92
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

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

Run Date: 08/29/2018
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SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 162 LEGACY POINT
 CLAYTON,GA 30525-0705

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	81.76	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,448.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	632.00	1,529.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	632.00	1,529.76

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

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

Run Date: 08/29/2018
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,979.58	ADJUSTMENTS	144.00
COVERED CHARGES	25,021.86	CONTRACTUAL ALLOW	24,021.86
NON-COVERD CHARGES	7,957.72	TOTAL MEDICAID LIAB	1,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	961.00
		TOTAL NUMBER OF CLAIMS	20

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

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

Run Date: 08/29/2018
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SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
 162 LEGACY POINT
 CLAYTON,GA 30525-0705

PROVIDER NUMBER
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88.44	142.64	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	931.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,744.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,433.00	5,927.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,417.00	538.00
EKG/ECG	438.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,468.90	180.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,334.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	699.08	702.08
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	468.00	468.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,021.86	7,957.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,021.86	7,957.72

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: 08/29/2018
Run Time: 00:54:59
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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: 08/29/2018
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,723.64	ADJUSTMENTS	4,675.86
COVERED CHARGES	24,176.80	CONTRACTUAL ALLOW	14,825.08
NON-COVERD CHARGES	546.84	TOTAL MEDICAID LIAB	9,351.72
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	9,348.72
		TOTAL NUMBER OF CLAIMS	2

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

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 162 LEGACY POINT 000001559A SERVICE DATES 01/01/17 THROUGH 12/31/17
 CLAYTON,GA 30525-0705 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	729.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,983.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	772.00	110.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,922.68	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,000.00	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	620.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	248.72	436.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,900.60	0.00			
			TOTAL ANCILLARY	24,176.80	546.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,176.80	546.84

Report : 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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN
162 LEGACY POINT
CLAYTON,GA 30525-0705

PROVIDER NUMBER
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,036,296.01	ADJUSTMENTS	797,733.62
COVERED CHARGES	48,731,447.01	CONTRACTUAL ALLOW	41,148,308.98
NON-COVERD CHARGES	1,304,849.00	TOTAL MEDICAID LIAB	7,583,138.03
		LESS: COB	54,905.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,528,232.51

TOTAL NUMBER OF ADMISSIONS 660

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,277		0	2,400,096.50		431,846.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,277		0	2,400,096.50		431,846.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	896		0	2,194,724.50		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		7	0.00		7,427.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	896		7	2,194,724.50		7,427.00
TOTAL ACCOMODATIONS	4,173		7	4,594,821.00		439,273.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,440,013.05	23,379.00	OTHER LAB	289,910.00	0.00
MED/SURG SUPPLY	2,530,878.50	15,742.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,803,875.25	53,615.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,150,259.00	1,618.00	OTHER THERAPEUTIC SVC	0.00	6,313.00
CT SCAN	2,710,059.00	31,046.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	759,717.79	470.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	514,982.00	1,136.00	MRI SERVICES	454,683.00	0.00
IV THERAPY	120,330.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,297,825.00	500,625.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,102,052.25	4,250.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	769,424.00	0.00	AMBULANCE	0.00	1,154.00
GI SERVICES	91,349.00	8,762.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,523,645.00	3,338.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	441,794.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	26,584.50
LABORATORY PATHOLOGIC	296,626.50	0.00	INJECTABLE DRUGS	4,396,516.51	63,369.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	377,240.58	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	186,693.93	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	134,825.00	2,261.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,402.00	2,464.00	TRAUMA RESPONSE	0.00	9,900.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,782,508.00	220.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	272,179.00	17,037.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	372,451.00	81,943.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	501,598.00	7,127.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,698,333.40	3,222.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,380.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,075.00	0.00			
			TOTAL ANCILLARY	44,136,626.01	865,576.00
			TOTAL ACCOMODATIONS	4,594,821.00	439,273.00
			TOTAL CHARGES	48,731,447.01	1,304,849.00

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	2017118071941	03/17/17 - 03/24/17	05/08/17	0.00	0.00	0.00	0.00	0.00
24	2017126003962	03/15/17 - 03/22/17	05/15/17	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,897.50	ADJUSTMENTS	0.00
COVERED CHARGES	13,657.50	CONTRACTUAL ALLOW	2,481.12
NON-COVERD CHARGES	240.00	TOTAL MEDICAID LIAB	11,176.38
		LESS: COB	11,176.38
		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	1,486.00		240.00
ROUTINE NURSERY	0		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	1,486.00		240.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,486.00		240.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	372.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,312.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	809.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	470.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	568.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	150.75	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	2,609.00	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	111.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	886.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	360.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,523.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,171.50	0.00
			TOTAL ACCOMODATIONS	1,486.00	240.00
			TOTAL CHARGES	13,657.50	240.00

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: 08/29/2018
Run Time: 00:43:58
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,081,433.11	ADJUSTMENTS	33,388.73
COVERED CHARGES	20,467,865.65	CONTRACTUAL ALLOW	18,527,842.63
NON-COVERD CHARGES	1,613,567.46	TOTAL MEDICAID LIAB	1,940,023.02
		LESS: COB	935.76
		LESS: COPAYMENT	5,433.61
		REIMBURSEMENT	1,933,653.65
		ALL OTHER	1,782,108.19
		FEE SCHEDULE-LAB	138,622.98
		INJECTABLE DRUGS	12,922.48
		TOTAL NUMBER OF CLAIMS	3,643

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	319,219.19	5,385.25	OTHER LAB	109,987.00	0.00
MED/SURG SUPPLY	614,711.25	8,640.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,109,495.00	64,220.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,489,467.00	495,862.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,819.50	53,447.50	FEE SCHEDULE LAB	5,224,193.97	67,402.75
EKG/ECG	414,794.00	1,078.00	MRI SERVICES	226,272.00	42,583.00
IV THERAPY	950,059.00	11,231.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,098,432.00	228,833.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,615.00	10,386.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	341,762.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	126,594.84	31,555.16	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,468,916.75	8,843.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	262,342.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	87,268.76	15,861.80
RADIOLOGY THERAPEUTIC	57,559.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	63,618.00	50,417.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,596.00	7,283.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	45,483.00	1,890.75	TRAUMA RESPONSE	0.00	39,600.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	294,181.00	7,400.00
LITHOTRIPSY	292,776.00	73,194.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	154,149.50	39,514.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	36,550.00	9,601.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	465,144.00	221,812.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	722,227.00	83,135.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,092.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	379,540.89	34,392.00			
			TOTAL ANCILLARY	20,467,865.65	1,613,567.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,467,865.65	1,613,567.46

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	434,625.05	ADJUSTMENTS	0.00
COVERED CHARGES	250,367.05	CONTRACTUAL ALLOW	163,928.17
NON-COVERD CHARGES	184,258.00	TOTAL MEDICAID LIAB	86,438.88
		LESS: COB	86,347.31
		LESS: COPAYMENT	91.57
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,884.11	95.00	OTHER LAB	1,789.00	0.00
MED/SURG SUPPLY	13,649.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,838.00	681.00	OTHER THERAPEUTIC SVC	0.00	831.00
CT SCAN	16,302.00	70,811.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,355.75	1,504.00
EKG/ECG	5,112.00	1,704.00	MRI SERVICES	0.00	6,200.00
IV THERAPY	7,087.44	797.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,421.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	769.50	606.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,127.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,364.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,258.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,207.75	0.00
RADIOLOGY THERAPEUTIC	2,774.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	8,463.00	TRAUMA RESPONSE	0.00	9,900.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,039.00	0.00
LITHOTRIPSY	0.00	36,597.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,861.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,428.00	30,668.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,503.00	2,773.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,571.50	10,767.00			
			TOTAL ANCILLARY	250,367.05	184,258.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	250,367.05	184,258.00

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: 08/29/2018
Run Time: 00:44:06
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,071,877.75	ADJUSTMENTS	158.82
COVERED CHARGES	1,034,215.25	CONTRACTUAL ALLOW	1,016,090.69
NON-COVERD CHARGES	37,662.50	TOTAL MEDICAID LIAB	18,124.56
		LESS: COB	0.00
		LESS: COPAYMENT	756.00
		REIMBURSEMENT	17,368.56
		TOTAL NUMBER OF CLAIMS	324

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,557.25	0.00	OTHER LAB	5,367.00	0.00
MED/SURG SUPPLY	1,199.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,576.00	2,403.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	218,250.00	32,836.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	276,169.75	2,423.50
EKG/ECG	14,420.00	0.00	MRI SERVICES	21,975.00	0.00
IV THERAPY	25,911.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,840.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	994.50	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	365,598.25	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	1,446.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,911.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,034,215.25	37,662.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,034,215.25	37,662.50

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,822.75	ADJUSTMENTS	0.00
COVERED CHARGES	9,822.75	CONTRACTUAL ALLOW	7,935.06
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,887.69
		LESS: COB	1,884.69
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	5,030.75	0.00
EKG/ECG	568.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,224.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,822.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,822.75	0.00

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

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

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,827,310.50	ADJUSTMENTS	0.00
COVERED CHARGES	3,633,530.91	CONTRACTUAL ALLOW	3,452,323.59
NON-COVERD CHARGES	193,779.59	TOTAL MEDICAID LIAB	181,207.32
		LESS: COB	0.00
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	181,057.32

TOTAL NUMBER OF CLAIMS 34

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,630.00	44.00	OTHER LAB	2,357.00	0.00
MED/SURG SUPPLY	168,106.00	3,464.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,915.00	4,468.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,918.00	FEE SCHEDULE LAB	47,818.75	944.00
EKG/ECG	11,244.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	243.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,454,588.16	105,252.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	225.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,350.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,609.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,434.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,246.00	107.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,465.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	1,460,798.00	12,950.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	422.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	354,519.00	63,079.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,026.00	0.00			
			TOTAL ANCILLARY	3,633,530.91	193,779.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,633,530.91	193,779.59

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	153,841.50	ADJUSTMENTS	0.00
COVERED CHARGES	140,818.50	CONTRACTUAL ALLOW	83,957.36
NON-COVERD CHARGES	13,023.00	TOTAL MEDICAID LIAB	56,861.14
		LESS: COB	56,861.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,718.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,134.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	13,023.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,719.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,208.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31.75	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	130,725.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	140,818.50	13,023.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	140,818.50	13,023.00

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

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

Run Date: 08/29/2018
 Run Time: 00:26:55
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER 000001603A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,595,422.63	ADJUSTMENTS	551,362.20
COVERED CHARGES	20,637,913.13	CONTRACTUAL ALLOW	15,682,975.12
NON-COVERD CHARGES	957,509.50	TOTAL MEDICAID LIAB	4,954,938.01
		LESS: COB	57,951.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,896,986.35

TOTAL NUMBER OF ADMISSIONS 606

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,096		0	1,398,535.00		523,737.00
ROUTINE NURSERY	812		0	2,473,852.00		102,422.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,908		0	3,872,387.00		626,159.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	221		0	386,229.00		0.00
NICU	24		0	159,420.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	245		0	545,649.00		0.00
TOTAL ACCOMODATIONS	3,153		0	4,418,036.00		626,159.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,073,105.48	0.00	OTHER LAB	134,570.00	0.00
MED/SURG SUPPLY	1,046,084.24	777.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,287,937.99	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	243,718.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,128,308.00	4,774.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,066.29	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	188,815.00	0.00	MRI SERVICES	258,244.00	0.00
IV THERAPY	319,965.00	0.00	PROFESSIONAL FEES	0.00	639.00
OPERATING ROOM	688,960.08	1,249.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	544,387.00	13,926.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	814,002.35	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	336,089.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	169,661.00	2,775.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	732,598.47	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	222,262.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	54,893.50
LABORATORY PATHOLOGIC	87,807.00	0.00	INJECTABLE DRUGS	1,125,542.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,550.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,034.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	198,165.00	8,004.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,323.00	834.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	370,973.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	73,980.00
OTHER IMAGING SERVICE	201,200.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	461,779.00	153,076.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	87,718.00	16,423.00			
AUDIOLOGY	16,605.00	0.00			
CARDIOLOGY	1,155,083.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,864.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149,459.00	0.00			
			TOTAL ANCILLARY	16,219,877.13	331,350.50
			TOTAL ACCOMODATIONS	4,418,036.00	626,159.00
			TOTAL CHARGES	20,637,913.13	957,509.50

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016328092065	11/16/16 - 11/18/16	11/28/16	0.00	2,650.00	0.00	0.00	0.00
615	2216348000381	10/14/16 - 10/18/16	12/19/16	0.00	5,242.00	0.00	0.00	0.00
615	2016356001821	12/03/16 - 12/09/16	12/26/16	0.00	2,650.00	0.00	0.00	0.00
615	2216356000533	11/17/16 - 11/23/16	12/26/16	0.00	2,650.00	0.00	0.00	0.00
615	2017020071234	01/09/17 - 01/11/17	01/30/17	0.00	2,783.00	0.00	0.00	0.00
615	5917055000833	01/15/17 - 01/16/17	02/27/17	0.00	2,783.00	0.00	0.00	0.00
615	2017138115932	04/24/17 - 05/01/17	05/22/17	0.00	2,783.00	0.00	0.00	0.00
615	2017142035200	05/11/17 - 05/15/17	05/29/17	0.00	5,505.00	0.00	0.00	0.00
615	2217178000643	02/04/17 - 02/07/17	07/03/17	0.00	2,783.00	0.00	0.00	0.00
615	2017186218386	06/23/17 - 06/25/17	07/10/17	0.00	2,783.00	0.00	0.00	0.00
615	2017186219182	06/13/17 - 06/28/17	07/10/17	0.00	2,783.00	0.00	0.00	0.00
615	2317243000108	12/10/16 - 12/10/16	10/02/17	0.00	2,650.00	0.00	0.00	0.00
615	2017255044824	01/17/17 - 01/21/17	09/18/17	0.00	2,783.00	0.00	0.00	0.00
615	2017275048550	09/15/17 - 09/25/17	10/09/17	0.00	2,783.00	0.00	0.00	0.00
615	2317286000151	02/22/17 - 03/22/17	12/04/17	0.00	5,505.00	0.00	6,291.17	0.00
615	2217306002852	03/01/17 - 04/03/17	11/06/17	0.00	8,288.00	0.00	0.00	0.00
615	2117306000008	04/15/17 - 04/18/17	12/04/17	0.00	2,783.00	0.00	908.58	0.00
615	2017326092165	05/24/17 - 05/31/17	11/27/17	0.00	8,288.00	0.00	0.00	0.00
615	2218236002191	07/31/17 - 08/07/17	08/27/18	0.00	5,505.00	0.00	0.00	0.00
TOTAL				0.00	73,980.00	0.00	7,199.75	0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER 000001603A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,536.57	ADJUSTMENTS	0.00
COVERED CHARGES	78,029.57	CONTRACTUAL ALLOW	58,434.69
NON-COVERD CHARGES	507.00	TOTAL MEDICAID LIAB	19,594.88
		LESS: COB	19,594.88
		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	3,305.00		0.00
ROUTINE NURSERY	7		0	20,643.00		507.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	23,948.00		507.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	23,948.00		507.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,938.84	0.00	OTHER LAB	798.00	0.00
MED/SURG SUPPLY	4,111.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,693.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,486.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	3,817.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,148.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,053.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,781.00	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	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	561.00	0.00	INJECTABLE DRUGS	1,984.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	307.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	695.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	204.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,554.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	54,081.57	0.00
			TOTAL ACCOMODATIONS	23,948.00	507.00
			TOTAL CHARGES	78,029.57	507.00

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: 08/29/2018
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PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,420,796.24	ADJUSTMENTS	375,762.53
COVERED CHARGES	14,633,527.30	CONTRACTUAL ALLOW	12,970,454.59
NON-COVERD CHARGES	1,787,268.94	TOTAL MEDICAID LIAB	1,663,072.71
		LESS: COB	5,384.05
		LESS: COPAYMENT	3,593.82
		REIMBURSEMENT	1,654,094.84
		ALL OTHER	1,459,885.49
		FEE SCHEDULE-LAB	179,888.25
		INJECTABLE DRUGS	14,321.10

TOTAL NUMBER OF CLAIMS 4,246

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,931.51	5,776.74	OTHER LAB	185,308.00	2,674.00
MED/SURG SUPPLY	525,532.15	134,317.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	381,603.00	68,567.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,303,640.00	284,308.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	115,439.00	13,652.00	FEE SCHEDULE LAB	3,521,087.60	211,729.00
EKG/ECG	311,922.00	1,127.00	MRI SERVICES	393,036.00	24,197.00
IV THERAPY	712,025.00	21,199.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	603,744.22	196,722.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	2,800.00
RESPIRATORY SERVICES	27,720.75	14,495.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	384,103.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	210,525.42	74,945.58	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,997,774.00	38,885.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	228,946.00	0.00	DRUG-SPECIFIC/HOME IV	1,977.72	5,082.30
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	138,573.00	17,507.42
RADIOLOGY THERAPEUTIC	1,216.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,247.00	1,131.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,269.00	4,641.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	20,558.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27,589.00	14,190.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	126,386.93	108,648.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	24,277.00
OTHER IMAGING SERVICE	531,366.00	112,129.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	90,504.00	27,118.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	131,215.00	101,573.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	208,276.00	251,944.42			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,216.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	452,354.00	3,074.00			
			TOTAL ANCILLARY	14,633,527.30	1,787,268.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,633,527.30	1,787,268.94

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: 08/29/2018
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PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5917035000012	11/06/16 - 11/06/16	02/13/17	0.00	2,650.00	0.00	0.00	0.00
615	5917035000012	11/06/16 - 11/06/16	02/13/17	0.00	2,592.00	0.00	0.00	0.00
615	5917096002166	03/05/17 - 03/05/17	04/10/17	0.00	2,783.00	0.00	0.00	0.00
615	5917096002166	03/05/17 - 03/05/17	04/10/17	0.00	2,722.00	0.00	0.00	0.00
615	2217148000059	12/14/16 - 12/14/16	06/05/17	0.00	2,650.00	0.00	0.00	0.00
615	2217148000059	12/14/16 - 12/14/16	06/05/17	0.00	2,592.00	0.00	0.00	0.00
615	5917262000020	02/28/17 - 02/28/17	09/25/17	0.00	2,783.00	0.00	0.00	0.00
615	5917262000020	02/28/17 - 02/28/17	09/25/17	0.00	2,722.00	0.00	0.00	0.00
615	5917349000161	06/16/17 - 06/16/17	12/18/17	0.00	2,783.00	0.00	0.00	0.00
TOTAL				0.00	24,277.00	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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	271,521.14	ADJUSTMENTS	0.00
COVERED CHARGES	215,519.73	CONTRACTUAL ALLOW	161,737.35
NON-COVERD CHARGES	56,001.41	TOTAL MEDICAID LIAB	53,782.38
		LESS: COB	53,754.64
		LESS: COPAYMENT	27.74
		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

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,730.94	165.62	OTHER LAB	2,505.00	0.00
MED/SURG SUPPLY	2,462.75	419.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,272.00	850.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,080.00	27,176.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,188.00	430.00	FEE SCHEDULE LAB	59,390.70	2,556.70
EKG/ECG	1,853.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,974.00	726.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,422.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	747.00	686.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	8,765.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,173.00	1,703.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,965.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,660.34	91.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,140.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,409.00	834.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,802.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,732.00	5,286.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,118.00	1,249.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,485.00	122.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,320.00	0.00			
			TOTAL ANCILLARY	215,519.73	56,001.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	215,519.73	56,001.41

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: 08/29/2018
Run Time: 00:27:15
Page: 11

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	653,408.64	ADJUSTMENTS	1,409.44
COVERED CHARGES	636,765.73	CONTRACTUAL ALLOW	611,145.21
NON-COVERD CHARGES	16,642.91	TOTAL MEDICAID LIAB	25,620.52
		LESS: COB	0.00
		LESS: COPAYMENT	693.00
		REIMBURSEMENT	24,927.52
		TOTAL NUMBER OF CLAIMS	458

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	488.11	OTHER LAB	5,347.00	0.00
MED/SURG SUPPLY	1,963.00	19.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,837.00	2,949.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,751.00	2,583.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	233,091.40	6,408.80
EKG/ECG	10,563.00	0.00	MRI SERVICES	3,764.00	0.00
IV THERAPY	18,904.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,737.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	410.00	324.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,036.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	290,936.00	637.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,027.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,670.33	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	9,970.00	3,234.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,759.00	0.00			
			TOTAL ANCILLARY	636,765.73	16,642.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	636,765.73	16,642.91

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: 08/29/2018
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PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,605.83	ADJUSTMENTS	0.00
COVERED CHARGES	18,949.33	CONTRACTUAL ALLOW	11,476.24
NON-COVERD CHARGES	2,656.50	TOTAL MEDICAID LIAB	7,473.09
		LESS: COB	7,470.09
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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

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

Run Date: 08/29/2018
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SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	361.44	0.00	OTHER LAB	2,092.00	0.00
MED/SURG SUPPLY	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	8,752.90	2,656.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	623.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,972.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	147.99	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,949.33	2,656.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,949.33	2,656.50

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

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	225,260.09	ADJUSTMENTS	11,078.46
COVERED CHARGES	151,690.61	CONTRACTUAL ALLOW	140,600.15
NON-COVERD CHARGES	73,569.48	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	11,078.46

TOTAL NUMBER OF CLAIMS 2

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

PIEDMONT ROCKDALE HOSPITAL INC
 1412 MILSTEAD AVENUE, NE
 CONYERS,GA 30012-3877

PROVIDER NUMBER
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	600.94	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,434.00	39,626.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,298.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,751.00	185.00
EKG/ECG	363.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,204.00	212.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	115,312.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	550.87	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,079.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	1,517.77	299.54
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	3,560.97	32,646.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,620.00	0.00			
			TOTAL ANCILLARY	151,690.61	73,569.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	151,690.61	73,569.48

Report : 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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT ROCKDALE HOSPITAL INC
1412 MILSTEAD AVENUE, NE
CONYERS,GA 30012-3877

PROVIDER NUMBER
000001603A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	09/30/17
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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	186,066,951.74	ADJUSTMENTS	16,065,190.54
COVERED CHARGES	180,234,607.06	CONTRACTUAL ALLOW	122,656,449.94
NON-COVERD CHARGES	5,832,344.68	TOTAL MEDICAID LIAB	57,578,157.12
		LESS: COB	319,943.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	57,258,213.48

TOTAL NUMBER OF ADMISSIONS 2,757

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,300		1	18,756,491.00		4,612,658.00
ROUTINE NURSERY	705		0	1,815,780.00		8,060.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,005		1	20,572,271.00		4,620,718.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	1,641		0	9,976,459.50		0.00
PED ICU	4,655		0	21,322,909.00		13,663.50
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	6,296		0	31,299,368.50		13,663.50
TOTAL ACCOMODATIONS	19,301		1	51,871,639.50		4,634,381.50

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,166,353.44	76,237.75	OTHER LAB	375,352.00	0.00
MED/SURG SUPPLY	7,342,616.42	38,482.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,869,862.62	116,759.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,007,804.50	545.50	OTHER THERAPEUTIC SVC	35,680.50	113,887.00
CT SCAN	1,657,093.00	1,573.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	859,832.00	1,040.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	93,257.00	0.00	MRI SERVICES	1,586,871.00	17,405.00
IV THERAPY	45,094.00	1,109.50	PROFESSIONAL FEES	0.00	9,642.00
OPERATING ROOM	12,609,714.00	794.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,359,768.74	321,639.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,449,685.00	9,970.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,570,620.50	18,339.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	663,855.50	852.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,079,692.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	253,432.00	22,900.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	441,574.50	208.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	373,119.00	694.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,001.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	633.00	25,438.00	TRAUMA RESPONSE	0.00	32,174.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,628,193.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	398,586.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,301,951.00	103,417.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	57,588.00	2,989.00			
AUDIOLOGY	53,313.50	1,896.50			
CARDIOLOGY	950,365.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,770,311.00	4,011.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	360,747.50	258,956.00			
			TOTAL ANCILLARY	128,362,967.56	1,197,963.18
			TOTAL ACCOMODATIONS	51,871,639.50	4,634,381.50
			TOTAL CHARGES	180,234,607.06	5,832,344.68

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,981,108.75	ADJUSTMENTS	0.00
COVERED CHARGES	5,875,725.75	CONTRACTUAL ALLOW	3,110,893.02
NON-COVERD CHARGES	105,383.00	TOTAL MEDICAID LIAB	2,764,832.73
		LESS: COB	2,764,832.73
		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	250		0	377,979.50		68,137.00
ROUTINE NURSERY	119		0	426,421.50		139.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	369		0	804,401.00		68,276.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	194		0	1,179,423.00		0.00
PED ICU	47		0	216,014.50		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	241		0	1,395,437.50		0.00
TOTAL ACCOMODATIONS	610		0	2,199,838.50		68,276.50

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,018,740.00	1,238.50	OTHER LAB	9,497.00	0.00
MED/SURG SUPPLY	201,095.25	1,431.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	482,105.50	504.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	61,858.50	1,051.50	OTHER THERAPEUTIC SVC	1,615.00	3,995.50
CT SCAN	31,854.50	3,859.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,048.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,817.50	0.00	MRI SERVICES	6,402.50	0.00
IV THERAPY	1,109.50	0.00	PROFESSIONAL FEES	0.00	10,106.00
OPERATING ROOM	399,534.00	6,043.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	658,128.50	89.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	168,019.00	2,136.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,252.00	1,340.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,250.00	639.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	36,435.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	2,326.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,345.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,338.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	524.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	181,618.50	3,717.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,963.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,496.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	629.50	0.00			
CARDIOLOGY	45,617.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	161,063.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,728.00	432.00			
			TOTAL ANCILLARY	3,675,887.25	37,106.50
			TOTAL ACCOMODATIONS	2,199,838.50	68,276.50
			TOTAL CHARGES	5,875,725.75	105,383.00

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,781,597.00	ADJUSTMENTS	2,079,037.08
COVERED CHARGES	52,985,522.13	CONTRACTUAL ALLOW	39,587,492.10
NON-COVERD CHARGES	4,796,074.87	TOTAL MEDICAID LIAB	13,398,030.03
		LESS: COB	22,953.32
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	13,374,749.71
		ALL OTHER	11,745,589.13
		FEE SCHEDULE-LAB	526,363.24
		INJECTABLE DRUGS	1,102,797.34
		TOTAL NUMBER OF CLAIMS	20,196

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	957,210.25	4,689.25	OTHER LAB	417,445.00	3,801.00
MED/SURG SUPPLY	2,699,015.20	1,614.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,721,236.50	21,203.00	OTHER THERAPEUTIC SVC	0.00	6,271.50
CT SCAN	1,710,282.50	142,753.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,779,792.00	117,062.75	FEE SCHEDULE LAB	8,791,601.99	840,289.34
EKG/ECG	32,550.00	1,840.50	MRI SERVICES	3,999,347.00	233,943.50
IV THERAPY	1,173,602.00	51,181.50	PROFESSIONAL FEES	0.00	3,594.00
OPERATING ROOM	6,087,703.95	438,974.77	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	306,250.00	80,311.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,413,288.00	1,114.00	AMBULANCE	0.00	0.00
GI SERVICES	97,847.50	3,038.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,115,270.00	72,450.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	642,946.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,390,421.25	1,619,750.25
RADIOLOGY THERAPEUTIC	559,212.00	12,771.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	661,888.50	60,694.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	657,293.00	71,833.50	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	1,065,379.50	253,047.50	TRAUMA RESPONSE	0.00	39,455.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	227,541.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	723,668.50	22,782.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	919,035.50	5,344.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	224,207.50	28,551.00			
AUDIOLOGY	271,235.99	21,375.00			
CARDIOLOGY	82,869.00	65,837.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,081,778.50	2,809.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,175,604.00	567,692.00			
			TOTAL ANCILLARY	52,985,522.13	4,796,074.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,985,522.13	4,796,074.87

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,931,000.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,507,188.00	CONTRACTUAL ALLOW	353,759.40
NON-COVERD CHARGES	423,812.00	TOTAL MEDICAID LIAB	1,153,428.60
		LESS: COB	1,153,420.30
		LESS: COPAYMENT	8.30
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 474

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 01/01/17 THROUGH 12/31/17
 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	33,020.50	145.75	OTHER LAB	4,960.00	0.00
MED/SURG SUPPLY	89,377.50	127.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,095.00	1,555.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,124.00	20,413.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	47,945.50	18,100.50	FEE SCHEDULE LAB	200,662.00	20,394.50
EKG/ECG	976.50	0.00	MRI SERVICES	95,028.50	40,436.00
IV THERAPY	3,290.50	746.00	PROFESSIONAL FEES	0.00	8,204.50
OPERATING ROOM	210,334.00	58,418.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,953.00	2,036.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	159,781.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,197.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,106.00	1,729.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,301.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	174,124.50	177,202.00
RADIOLOGY THERAPEUTIC	120,091.50	594.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,376.50	15,931.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,538.00	12,562.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,277.00	13,417.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,022.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,676.00	644.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	35,192.50	7,437.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,396.50	1,293.00			
AUDIOLOGY	907.00	8,611.50			
CARDIOLOGY	0.00	5,550.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	51,716.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,717.50	8,264.50			
			TOTAL ANCILLARY	1,507,188.00	423,812.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,507,188.00	423,812.00

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 01/01/17 THROUGH 12/31/17
 ATLANTA,GA 30342-1605 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017194057795	01/03/17 - 01/03/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/04/17 - 01/04/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/05/17 - 01/05/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/09/17 - 01/09/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/10/17 - 01/10/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/11/17 - 01/11/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/12/17 - 01/12/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/13/17 - 01/13/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057795	01/17/17 - 01/17/17	07/17/17	0.00	0.00	0.00	136.64	0.00
932	2017194057796	01/18/17 - 01/18/17	07/17/17	0.00	0.00	0.00	22.75	0.00
932	2017194057796	01/19/17 - 01/19/17	07/17/17	0.00	0.00	0.00	22.75	0.00
932	2017194057797	01/20/17 - 01/20/17	07/17/17	0.00	0.00	0.00	115.78	0.00
932	2017194057797	01/23/17 - 01/23/17	07/17/17	0.00	0.00	0.00	115.78	0.00
932	2017194057797	01/24/17 - 01/24/17	07/17/17	0.00	0.00	0.00	115.78	0.00
932	2017194057797	01/25/17 - 01/25/17	07/17/17	0.00	0.00	0.00	115.78	0.00
932	2017194057797	01/26/17 - 01/26/17	07/17/17	0.00	0.00	0.00	115.78	0.00
932	2017198023315	02/09/17 - 02/09/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017198023315	02/10/17 - 02/10/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017198023315	02/13/17 - 02/13/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017198023315	02/14/17 - 02/14/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017198023315	02/15/17 - 02/15/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017198023315	02/16/17 - 02/16/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017198023315	02/17/17 - 02/17/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017198023315	02/20/17 - 02/20/17	07/24/17	0.00	0.00	0.00	10,697.87	0.00
932	2017272070444	02/23/17 - 02/23/17	10/09/17	0.00	0.00	0.00	2,780.62	0.00
932	2017272070444	02/24/17 - 02/24/17	10/09/17	0.00	0.00	0.00	2,780.62	0.00
932	2017272070444	02/27/17 - 02/27/17	10/09/17	0.00	0.00	0.00	2,780.62	0.00
932	2017272070444	02/28/17 - 02/28/17	10/09/17	0.00	0.00	0.00	2,780.62	0.00
TOTAL				0.00	0.00	0.00	98,559.60	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: 08/29/2018
Run Time: 00:58:28
Page: 10

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,406,187.57	ADJUSTMENTS	615.34
COVERED CHARGES	1,300,048.74	CONTRACTUAL ALLOW	1,243,325.58
NON-COVERD CHARGES	106,138.83	TOTAL MEDICAID LIAB	56,723.16
		LESS: COB	56.38
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	56,654.78
		TOTAL NUMBER OF CLAIMS	1,014

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,217.00	0.00	OTHER LAB	8,062.50	0.00
MED/SURG SUPPLY	12,781.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	93,957.50	834.00	OTHER THERAPEUTIC SVC	0.00	388.50
CT SCAN	31,461.50	19,950.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	616.50	360.00	FEE SCHEDULE LAB	262,454.24	45,059.58
EKG/ECG	2,278.50	0.00	MRI SERVICES	1,708.00	12,109.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	297.00
OPERATING ROOM	6,616.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,804.50	271.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,059.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	784,036.00	5,009.50	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	38,401.00	2,277.75
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	104.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	521.50	0.00	TRAUMA RESPONSE	0.00	1,196.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,146.00	8,372.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,461.50			
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	13,824.00	6,552.00			
			TOTAL ANCILLARY	1,300,048.74	106,138.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,300,048.74	106,138.83

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,766.00	ADJUSTMENTS	0.00
COVERED CHARGES	31,699.25	CONTRACTUAL ALLOW	18,630.10
NON-COVERD CHARGES	3,066.75	TOTAL MEDICAID LIAB	13,069.15
		LESS: COB	13,069.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	430.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,633.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	621.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,929.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,464.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	297.00
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	0.00	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	14,230.00	183.50	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	819.75	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,736.00	0.00			
			TOTAL ANCILLARY	31,699.25	3,066.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,699.25	3,066.75

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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,970,016.25	ADJUSTMENTS	323,941.02
COVERED CHARGES	6,491,852.00	CONTRACTUAL ALLOW	5,088,107.58
NON-COVERD CHARGES	478,164.25	TOTAL MEDICAID LIAB	1,403,744.42
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,403,744.42
		TOTAL NUMBER OF CLAIMS	169

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

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

PROVIDER NUMBER
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,893.50	0.00	OTHER LAB	526.50	743.00
MED/SURG SUPPLY	607,555.25	2,292.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,517.50	263.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,858.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,228.00	6,669.50	FEE SCHEDULE LAB	79,725.50	7,651.50
EKG/ECG	426.00	0.00	MRI SERVICES	38,409.00	0.00
IV THERAPY	105,202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	968,792.50	345,046.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,352.00	4,865.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	653,163.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,700.00	1,267.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	61,062.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,390,565.25	44,491.25
RADIOLOGY THERAPEUTIC	31,743.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	38,989.00	512.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,579.50	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	22,613.50	11,203.50	TRAUMA RESPONSE	0.00	1,196.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,063,982.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,004.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	64,433.50	4,903.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,193.50	1,099.50			
AUDIOLOGY	409.50	1,896.50			
CARDIOLOGY	1,208.00	785.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	44,096.50	5,695.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	78,624.00	37,584.00			
			TOTAL ANCILLARY	6,491,852.00	478,164.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,491,852.00	478,164.25

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	190,270.25	ADJUSTMENTS	0.00
COVERED CHARGES	180,048.75	CONTRACTUAL ALLOW	25,433.36
NON-COVERD CHARGES	10,221.50	TOTAL MEDICAID LIAB	154,615.39
		LESS: COB	154,609.39
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1001 JOHNSON FERRY RD NE	000001636A	SERVICE DATES	01/01/17	THROUGH	12/31/17
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	591.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28,637.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,816.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,137.50	555.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	2,382.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,745.50	6,043.50	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	29,910.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,945.75	1,063.50
RADIOLOGY THERAPEUTIC	1,184.50	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	177.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,656.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,304.00	0.00			
			TOTAL ANCILLARY	180,048.75	10,221.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	180,048.75	10,221.50

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,490.28	ADJUSTMENTS	6,561.50
COVERED CHARGES	87,521.54	CONTRACTUAL ALLOW	24,326.13
NON-COVERD CHARGES	51,968.74	TOTAL MEDICAID LIAB	63,195.41
		LESS: COB	5,375.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	57,819.82

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	24		0	22,452.00		50,390.64
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	24		0	22,452.00		50,390.64
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	24		0	22,452.00		50,390.64

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,532.66	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,400.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,592.82	0.00	EDUCATION & TRAINING	95.44	0.00
RADIOLOGY-DIAGNOSTIC	792.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,932.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,379.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,271.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,343.09	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	9,475.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,820.00	1,578.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,932.76	0.00			
			TOTAL ANCILLARY	65,069.54	1,578.10
			TOTAL ACCOMODATIONS	22,452.00	50,390.64
			TOTAL CHARGES	87,521.54	51,968.74

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
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: 08/29/2018
Run Time: 00:51:08
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,048,793.98	ADJUSTMENTS	65,241.51
COVERED CHARGES	979,174.09	CONTRACTUAL ALLOW	660,681.28
NON-COVERD CHARGES	69,619.89	TOTAL MEDICAID LIAB	318,492.81
		LESS: COB	1,387.06
		LESS: COPAYMENT	582.00
		REIMBURSEMENT	316,523.75
		ALL OTHER	248,655.15
		FEE SCHEDULE-LAB	67,817.06
		INJECTABLE DRUGS	51.54
		TOTAL NUMBER OF CLAIMS	1,377

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,216.06	107.34	OTHER LAB	6,171.65	0.00
MED/SURG SUPPLY	1,222.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	286.32
RADIOLOGY-DIAGNOSTIC	39,292.51	1,564.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,904.80	3,576.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,603.50	28,288.67	FEE SCHEDULE LAB	374,710.66	11,188.28
EKG/ECG	12,588.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	33,604.26	2,016.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	144,118.66	19,304.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,806.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	154,286.24	1,659.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127.27	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	1,599.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,432.20	708.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,489.44	918.36			
			TOTAL ANCILLARY	979,174.09	69,619.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	979,174.09	69,619.89

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

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Page: 6

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	448.64	ADJUSTMENTS	0.00
COVERED CHARGES	436.64	CONTRACTUAL ALLOW	135.22
NON-COVERD CHARGES	12.00	TOTAL MEDICAID LIAB	301.42
		LESS: COB	301.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	73.68	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	81.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	436.64	12.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	436.64	12.00

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,379.26	ADJUSTMENTS	94.00
COVERED CHARGES	49,776.54	CONTRACTUAL ALLOW	44,826.54
NON-COVERD CHARGES	602.72	TOTAL MEDICAID LIAB	4,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	4,770.00
		TOTAL NUMBER OF CLAIMS	99

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,516.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,267.40	296.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,148.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,603.56	144.00
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,419.22	162.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,578.18	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,590.43	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	480.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	49,776.54	602.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,776.54	602.72

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,521.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,521.40	CONTRACTUAL ALLOW	625.51
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	895.89
		LESS: COB	895.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	142.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,058.90	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	319.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,521.40	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,521.40	0.00

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

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

Run Date: 08/29/2018
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC
215 MIMS RD
SYLVANIA,GA 30467-1994

PROVIDER NUMBER
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,783.06	ADJUSTMENTS	9,719.78
COVERED CHARGES	80,966.43	CONTRACTUAL ALLOW	56,651.98
NON-COVERD CHARGES	816.63	TOTAL MEDICAID LIAB	24,314.45
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	24,200.45
		TOTAL NUMBER OF CLAIMS	5

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,287.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
RADIOLOGY-DIAGNOSTIC	110.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,789.36	180.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,998.17	588.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	319.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,313.25	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	1,122.94	0.00			
			TOTAL ANCILLARY	80,966.43	816.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,966.43	816.63

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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
 Run Time: 00:34:29
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER 000001713A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,664,657.79	ADJUSTMENTS	828,167.57
COVERED CHARGES	14,492,818.60	CONTRACTUAL ALLOW	12,114,825.74
NON-COVERD CHARGES	1,171,839.19	TOTAL MEDICAID LIAB	2,377,992.86
		LESS: COB	5,653.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,372,339.21

TOTAL NUMBER OF ADMISSIONS 218

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	796		0	985,425.00		382,459.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	796		0	985,425.00		382,459.00
SPECIAL CARE SERVICES						
CCU	9		0	39,528.00		0.00
ICU	767		0	2,363,053.40		85,230.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	776		0	2,402,581.40		85,230.00
TOTAL ACCOMODATIONS	1,572		0	3,388,006.40		467,689.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,823,387.80	299,882.95	OTHER LAB	44,428.34	1,719.61
MED/SURG SUPPLY	619,072.12	91,216.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,434,149.64	61,923.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	224,961.38	5,128.84	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	637,657.35	37,966.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,736.60	24,548.14	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	71,101.07	392.39	MRI SERVICES	148,538.16	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	394,953.01	6,804.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	986,927.54	44,288.01	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	152,446.64	0.00	AMBULANCE	0.00	0.00
GI SERVICES	45,499.30	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	479,297.27	4,210.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,714.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	36,686.79	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,663.15	16,801.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,570.88	7,405.99	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	81,017.82	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	550.53	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	59,621.40	0.00	IMPL DEV CHARGE PATIENTS	60,384.08	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	86,158.43	1,361.84			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	115,794.88	98,024.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	232,225.13	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	228,084.83	2,475.56			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,026.08	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,157.10	0.00			
			TOTAL ANCILLARY	11,104,812.20	704,150.19
			TOTAL ACCOMODATIONS	3,388,006.40	467,689.00
			TOTAL CHARGES	14,492,818.60	1,171,839.19

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

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

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SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	597,115.48	ADJUSTMENTS	0.00
COVERED CHARGES	593,641.48	CONTRACTUAL ALLOW	499,381.44
NON-COVERD CHARGES	3,474.00	TOTAL MEDICAID LIAB	94,260.04
		LESS: COB	94,260.04
		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	9		0	11,781.00		3,474.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	11,781.00		3,474.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	29		0	83,493.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	29		0	83,493.00		0.00
TOTAL ACCOMODATIONS	38		0	95,274.00		3,474.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	259,211.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40,249.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	46,764.83	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,476.83	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,839.16	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,614.59	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	392.39	0.00	MRI SERVICES	7,595.18	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	63,420.53	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,988.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,294.27	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,967.75	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	5,811.80	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,681.55	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,559.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,097.70	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	498,367.48	0.00
			TOTAL ACCOMODATIONS	95,274.00	3,474.00
			TOTAL CHARGES	593,641.48	3,474.00

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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WELLSTAR ATLANTA MEDICAL CENTER , INC
1170 CLEVELAND AVE
EAST POINT,GA 30344-3615

PROVIDER NUMBER
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,144,687.41	ADJUSTMENTS	95,399.07
COVERED CHARGES	7,736,240.32	CONTRACTUAL ALLOW	7,128,895.53
NON-COVERD CHARGES	408,447.09	TOTAL MEDICAID LIAB	607,344.79
		LESS: COB	1,729.15
		LESS: COPAYMENT	771.00
		REIMBURSEMENT	604,844.64
		ALL OTHER	545,668.58
		FEE SCHEDULE-LAB	51,024.33
		INJECTABLE DRUGS	8,151.73
		TOTAL NUMBER OF CLAIMS	1,765

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	356,444.44	860.25	OTHER LAB	36,091.17	0.00
MED/SURG SUPPLY	210,877.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	465,375.23	25,039.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,485,428.48	84,003.99	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	970.64	FEE SCHEDULE LAB	1,059,715.79	8,567.16
EKG/ECG	115,755.05	392.39	MRI SERVICES	123,764.17	22,312.33
IV THERAPY	454,397.00	13,133.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	295,352.30	28,242.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,407.14	5,416.73	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	205,802.08	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,646.27	9,980.13	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,807,496.93	7,171.77	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,868.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	444,950.31	101,050.46
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	474.36	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,109.42	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	50,678.19	0.00	IMPL DEV CHARGE PATIENTS	4,930.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	267,394.31	58,541.11			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,743.36	19,035.78			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,773.42	8,319.96			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	37,204.99	12,824.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	57,959.24	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,184.28	0.00			
			TOTAL ANCILLARY	7,736,240.32	408,447.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,736,240.32	408,447.09

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,849.88	ADJUSTMENTS	0.00
COVERED CHARGES	21,677.59	CONTRACTUAL ALLOW	18,075.18
NON-COVERD CHARGES	10,172.29	TOTAL MEDICAID LIAB	3,602.41
		LESS: COB	3,602.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	139.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,743.85	797.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,967.28	8,381.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,629.78	0.00
EKG/ECG	392.39	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	744.41	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	7,729.05	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	249.55	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	993.69	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,677.59	10,172.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,677.59	10,172.29

Report : CLM-0808-0
Process : CLMJ0800
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	388,658.09	ADJUSTMENTS	104.75
COVERED CHARGES	380,240.39	CONTRACTUAL ALLOW	368,660.81
NON-COVERD CHARGES	8,417.70	TOTAL MEDICAID LIAB	11,579.58
		LESS: COB	0.00
		LESS: COPAYMENT	425.09
		REIMBURSEMENT	11,154.49
		TOTAL NUMBER OF CLAIMS	207

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 ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,315.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,962.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,153.74	2,577.12	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,571.68	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	755.96	FEE SCHEDULE LAB	72,393.48	175.42
EKG/ECG	3,923.90	0.00	MRI SERVICES	7,595.18	0.00
IV THERAPY	19,085.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	198,955.55	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	13,338.41	2,748.71
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	993.69	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,320.25	2,160.49			
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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,631.12	0.00			
			TOTAL ANCILLARY	380,240.39	8,417.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	380,240.39	8,417.70

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

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

Run Date: 08/29/2018
Run Time: 00:34:35
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
Run Time: 00:34:35
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,380.51	ADJUSTMENTS	0.00
COVERED CHARGES	83,875.06	CONTRACTUAL ALLOW	77,740.20
NON-COVERD CHARGES	1,505.45	TOTAL MEDICAID LIAB	6,134.86
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	6,131.86

TOTAL NUMBER OF CLAIMS 1

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

WELLSTAR ATLANTA MEDICAL CENTER , INC
 1170 CLEVELAND AVE
 EAST POINT,GA 30344-3615

PROVIDER NUMBER
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	5,525.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	5,875.54	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,987.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,057.93	1,505.45
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	69,428.74	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	0.00	0.00			
			TOTAL ANCILLARY	83,875.06	1,505.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,875.06	1,505.45

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:34:59
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,049,389.02	ADJUSTMENTS	1,425,897.37
COVERED CHARGES	26,443,055.77	CONTRACTUAL ALLOW	17,550,223.28
NON-COVERD CHARGES	606,333.25	TOTAL MEDICAID LIAB	8,892,832.49
		LESS: COB	25,959.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,866,872.74

TOTAL NUMBER OF ADMISSIONS 889

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,151		0	2,450,475.00		317,577.75
ROUTINE NURSERY	312		0	238,947.00		22,607.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,463		0	2,689,422.00		340,184.75
SPECIAL CARE SERVICES						
CCU	212		0	406,644.00		0.00
ICU	548		0	1,022,649.00		0.00
NICU	23		0	39,651.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	783		0	1,468,944.00		0.00
TOTAL ACCOMODATIONS	4,246		0	4,158,366.00		340,184.75

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,882,475.62	1,961.50	OTHER LAB	143,495.00	0.00
MED/SURG SUPPLY	1,540,450.50	19,417.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,628,218.98	23,886.00	EDUCATION & TRAINING	11,604.00	116.00
RADIOLOGY-DIAGNOSTIC	296,031.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,018,609.00	4,116.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	158,358.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	145,434.00	0.00	MRI SERVICES	214,506.50	0.00
IV THERAPY	237,229.00	1,863.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,454,623.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	149,922.00	4,375.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,578,015.50	3,980.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	312,771.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	159,655.00	1,864.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	548,568.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	205,627.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	68,221.50	0.00	INJECTABLE DRUGS	3,075,199.42	0.00
RADIOLOGY THERAPEUTIC	34,082.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	51,179.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,951.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	108,570.00	3,173.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,022.25	2,280.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,146,105.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	140,679.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	167,306.50	196,986.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,578.00	0.00			
AUDIOLOGY	42,591.00	0.00			
CARDIOLOGY	1,293,068.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,819.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	365,723.50	2,130.00			
			TOTAL ANCILLARY	22,284,689.77	266,148.50
			TOTAL ACCOMODATIONS	4,158,366.00	340,184.75
			TOTAL CHARGES	26,443,055.77	606,333.25

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	150,840.75	ADJUSTMENTS	0.00
COVERED CHARGES	144,226.75	CONTRACTUAL ALLOW	43,675.59
NON-COVERD CHARGES	6,614.00	TOTAL MEDICAID LIAB	100,551.16
		LESS: COB	100,551.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	35		0	27,315.00		3,166.00
ROUTINE NURSERY	6		0	5,205.00		646.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	41		0	32,520.00		3,812.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	32,520.00		3,812.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,927.00	0.00	OTHER LAB	4,207.00	0.00
MED/SURG SUPPLY	6,173.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,753.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,412.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,515.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	724.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,520.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,472.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,117.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,051.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,460.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,459.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	720.00	0.00	INJECTABLE DRUGS	7,821.75	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	363.50	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	2,390.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,728.00	2,802.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	864.00	0.00			
CARDIOLOGY	1,378.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,651.50	0.00			
			TOTAL ANCILLARY	111,706.75	2,802.00
			TOTAL ACCOMODATIONS	32,520.00	3,812.00
			TOTAL CHARGES	144,226.75	6,614.00

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: 08/29/2018
Run Time: 00:35:08
Page: 5

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,868,108.17	ADJUSTMENTS	843,404.05
COVERED CHARGES	16,922,364.13	CONTRACTUAL ALLOW	12,946,604.92
NON-COVERD CHARGES	1,945,744.04	TOTAL MEDICAID LIAB	3,975,759.21
		LESS: COB	6,632.14
		LESS: COPAYMENT	10,024.20
		REIMBURSEMENT	3,959,102.87
		ALL OTHER	2,977,203.10
		FEE SCHEDULE-LAB	336,403.54
		INJECTABLE DRUGS	645,496.23

TOTAL NUMBER OF CLAIMS 8,843

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,191,456.18	0.00	OTHER LAB	137,522.00	1,240.00
MED/SURG SUPPLY	434,554.75	3,007.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,524.00	1,381.00
RADIOLOGY-DIAGNOSTIC	485,731.00	43,706.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,730,356.00	270,158.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	7,944.00	FEE SCHEDULE LAB	2,245,756.76	133,407.68
EKG/ECG	227,216.00	10,498.00	MRI SERVICES	202,506.00	57,366.00
IV THERAPY	976,443.00	17,557.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	875,085.26	178,600.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151,143.00	34,031.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	357,177.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	112,358.00	63,674.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,673,213.00	2,577.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	471,670.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,257,957.01	604,046.62
RADIOLOGY THERAPEUTIC	353,058.00	122,848.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,546.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,064.00	11,227.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,102.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89,721.50	5,109.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	133,031.00	1,216.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	589,006.00	127,901.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	50,259.00	42,964.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	134,096.00	2,262.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	271,426.00	147,252.00			
AMBULATORY SURGERY	4,254.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,134.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	741,645.67	49,123.00			
			TOTAL ANCILLARY	16,922,364.13	1,945,744.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,922,364.13	1,945,744.04

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GEORGIA MEDICAL CENTER
2501 N PATTERSON ST
VALDOSTA,GA 31602-1735

PROVIDER NUMBER
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	262,064.14	ADJUSTMENTS	0.00
COVERED CHARGES	197,828.46	CONTRACTUAL ALLOW	57,358.59
NON-COVERD CHARGES	64,235.68	TOTAL MEDICAID LIAB	140,469.87
		LESS: COB	140,393.93
		LESS: COPAYMENT	75.94
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,550.41	4.34	OTHER LAB	1,309.00	0.00
MED/SURG SUPPLY	6,715.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	9.00	EDUCATION & TRAINING	0.00	348.00
RADIOLOGY-DIAGNOSTIC	4,315.00	1,024.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,111.00	14,649.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,493.25	1,572.00
EKG/ECG	1,629.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,899.00	106.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,268.00	5,780.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,104.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,062.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,584.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,849.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,625.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	58,324.55	458.34
RADIOLOGY THERAPEUTIC	0.00	12,948.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	142.00	92.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	39.00	15,553.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,000.00	1,487.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,011.00	934.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	4,110.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,382.00	577.00			
			TOTAL ANCILLARY	197,828.46	64,235.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	197,828.46	64,235.68

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	185,109.05	ADJUSTMENTS	264.70
COVERED CHARGES	172,671.20	CONTRACTUAL ALLOW	159,021.84
NON-COVERD CHARGES	12,437.85	TOTAL MEDICAID LIAB	13,649.36
		LESS: COB	0.00
		LESS: COPAYMENT	544.13
		REIMBURSEMENT	13,105.23
		TOTAL NUMBER OF CLAIMS	244

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,903.20	0.00	OTHER LAB	499.00	0.00
MED/SURG SUPPLY	1,325.00	162.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,500.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,374.00	8,742.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,698.00	2,070.00
EKG/ECG	2,353.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,753.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,372.00	196.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	97,813.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,721.00	82.85
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	142.00	92.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,218.00	1,093.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	172,671.20	12,437.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	172,671.20	12,437.85

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,809.56	ADJUSTMENTS	0.00
COVERED CHARGES	8,094.42	CONTRACTUAL ALLOW	4,797.88
NON-COVERD CHARGES	715.14	TOTAL MEDICAID LIAB	3,296.54
		LESS: COB	3,287.54
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.67	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	366.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,308.00	116.00
EKG/ECG	362.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,717.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	308.75	6.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	593.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,094.42	715.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,094.42	715.14

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,959,887.85	ADJUSTMENTS	232,497.66
COVERED CHARGES	4,570,108.58	CONTRACTUAL ALLOW	3,555,331.49
NON-COVERD CHARGES	389,779.27	TOTAL MEDICAID LIAB	1,014,777.09
		LESS: COB	0.00
		LESS: COPAYMENT	1,203.00
		REIMBURSEMENT	1,013,574.09

TOTAL NUMBER OF CLAIMS 183

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

SOUTH GEORGIA MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
2501 N PATTERSON ST	000001724A	SERVICE DATES	10/01/16	THROUGH	09/30/17
VALDOSTA,GA 31602-1735		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,860.08	0.00	OTHER LAB	1,022.00	0.00
MED/SURG SUPPLY	53,477.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	116.00	0.00
RADIOLOGY-DIAGNOSTIC	2,760.00	1,010.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,858.00	9,159.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	45,532.00	3,727.00
EKG/ECG	2,353.00	362.00	MRI SERVICES	0.00	0.00
IV THERAPY	229,654.00	1,168.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,822.00	15,400.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,114.00	784.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,169.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,952.00	4,952.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,467.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,309.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,130,903.75	148,273.27
RADIOLOGY THERAPEUTIC	340,579.00	14,702.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	92.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	307,519.00	1,216.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,675.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,112.00	3,736.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	814.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	106,794.00	184,349.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,154.50	941.00			
			TOTAL ANCILLARY	4,570,108.58	389,779.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,570,108.58	389,779.27

Report : 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: 08/29/2018
Run Time: 00:35:43
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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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
Run Time: 00:35:52
Page: 1

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	10/01/16	THROUGH	09/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
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: 08/29/2018
Run Time: 00:35:52
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,435,700.23	ADJUSTMENTS	50,302.47
COVERED CHARGES	1,224,820.67	CONTRACTUAL ALLOW	907,927.07
NON-COVERD CHARGES	210,879.56	TOTAL MEDICAID LIAB	316,893.60
		LESS: COB	65.22
		LESS: COPAYMENT	834.00
		REIMBURSEMENT	315,994.38
		ALL OTHER	306,276.97
		FEE SCHEDULE-LAB	9,347.22
		INJECTABLE DRUGS	370.19

TOTAL NUMBER OF CLAIMS 486

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,072.21	0.00	OTHER LAB	4,551.00	0.00
MED/SURG SUPPLY	46,828.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,525.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,483.00	17,491.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,899.00	FEE SCHEDULE LAB	45,918.00	1,587.00
EKG/ECG	1,991.00	181.00	MRI SERVICES	15,160.00	20,941.00
IV THERAPY	97.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	345,080.95	121,946.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	133,557.00	297.00	AMBULANCE	0.00	0.00
GI SERVICES	75,526.01	33,544.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	415.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	129,131.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,387.00	1,870.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,275.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	341.00	89.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,542.00	1,800.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,860.00	1,612.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,411.00	1,868.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	181,202.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,742.00	1,478.00			
			TOTAL ANCILLARY	1,224,820.67	210,879.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,224,820.67	210,879.56

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

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

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,214.40	ADJUSTMENTS	0.00
COVERED CHARGES	48,011.40	CONTRACTUAL ALLOW	11,462.83
NON-COVERD CHARGES	6,203.00	TOTAL MEDICAID LIAB	36,548.57
		LESS: COB	36,533.57
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,266.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,979.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	298.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,111.00	1,749.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	144.00	9.00
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	20,964.00	3,884.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,138.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,585.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,453.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,165.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,872.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	854.00	561.00			
			TOTAL ANCILLARY	48,011.40	6,203.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,011.40	6,203.00

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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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	10/01/16	THROUGH	09/30/17
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

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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

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

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

PROVIDER NUMBER
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,449.97	ADJUSTMENTS	0.00
COVERED CHARGES	71,730.47	CONTRACTUAL ALLOW	56,123.75
NON-COVERD CHARGES	9,719.50	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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,134.22	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,756.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	340.00	372.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	186.00	9.00
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	18,250.00	9,000.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,366.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,443.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	806.25	30.50
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	19,907.00	0.00
LITHOTRIPSY	15,361.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	308.00			
			TOTAL ANCILLARY	71,730.47	9,719.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	71,730.47	9,719.50

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

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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	10/01/16	THROUGH	09/30/17
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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,292,505.81	ADJUSTMENTS	159,324.42
COVERED CHARGES	16,614,048.47	CONTRACTUAL ALLOW	10,360,462.90
NON-COVERD CHARGES	1,678,457.34	TOTAL MEDICAID LIAB	6,253,585.57
		LESS: COB	80,695.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,172,889.72

TOTAL NUMBER OF ADMISSIONS 865

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,161		0	3,244,315.25		1,617,685.75
ROUTINE NURSERY	72		0	41,580.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1.00
TOTAL ROUTINE	5,233		0	3,285,895.25		1,617,686.75
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	355		0	493,893.75		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	355		0	493,893.75		0.00
TOTAL ACCOMODATIONS	5,588		0	3,779,789.00		1,617,686.75

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,851,852.67	0.00	OTHER LAB	79,642.25	49.00
MED/SURG SUPPLY	1,138,997.82	7,077.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,683,468.25	54.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	249,855.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	554,688.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	251,900.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	140,055.25	0.00	MRI SERVICES	224,602.00	547.00
IV THERAPY	149,828.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	970,232.00	1,333.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	92,149.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	532,722.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	367,386.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	126,696.75	2,353.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	598,761.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,106.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	189,751.00	0.00	INJECTABLE DRUGS	20,965.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	127,634.44	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,738.90	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	76,788.25	15,709.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	44.00	3,573.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	568,359.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	52,185.75	4,197.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	132,555.25	7,263.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	45,289.00	13,679.25			
AUDIOLOGY	10,982.50	0.00			
CARDIOLOGY	278,445.50	58.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,143.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	195,432.12	4,873.75			
			TOTAL ANCILLARY	12,834,259.47	60,770.59
			TOTAL ACCOMODATIONS	3,779,789.00	1,617,686.75
			TOTAL CHARGES	16,614,048.47	1,678,457.34

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	287,719.13	ADJUSTMENTS	0.00
COVERED CHARGES	268,064.38	CONTRACTUAL ALLOW	119,396.67
NON-COVERD CHARGES	19,654.75	TOTAL MEDICAID LIAB	148,667.71
		LESS: COB	148,667.71
		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	61		0	38,600.00		19,392.25
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	61		0	38,600.00		19,392.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	8		0	11,130.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8		0	11,130.00		0.00
TOTAL ACCOMODATIONS	69		0	49,730.00		19,392.25

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,851.88	0.00	OTHER LAB	889.00	0.00
MED/SURG SUPPLY	20,595.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	44,505.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,010.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,112.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,375.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,755.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,623.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,435.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,186.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,740.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,258.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,068.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,129.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,132.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,586.00	0.00	INJECTABLE DRUGS	400.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	954.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	746.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,021.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,367.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	949.00	262.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	921.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	721.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	218,334.38	262.50
			TOTAL ACCOMODATIONS	49,730.00	19,392.25
			TOTAL CHARGES	268,064.38	19,654.75

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: 08/29/2018
Run Time: 00:37:49
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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,026,854.50	ADJUSTMENTS	429,103.22
COVERED CHARGES	8,374,556.01	CONTRACTUAL ALLOW	6,304,970.56
NON-COVERD CHARGES	652,298.49	TOTAL MEDICAID LIAB	2,069,585.45
		LESS: COB	11,497.44
		LESS: COPAYMENT	3,445.66
		REIMBURSEMENT	2,054,642.35
		ALL OTHER	1,839,696.30
		FEE SCHEDULE-LAB	210,664.97
		INJECTABLE DRUGS	4,281.08
		TOTAL NUMBER OF CLAIMS	4,197

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	400,495.88	0.00	OTHER LAB	45,787.75	1,039.00
MED/SURG SUPPLY	623,638.94	1,109.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420,049.04	8,987.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	722,760.75	57,389.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,869.25	19,387.03	FEE SCHEDULE LAB	1,692,729.00	52,224.50
EKG/ECG	178,594.00	3,126.00	MRI SERVICES	145,299.00	21,164.75
IV THERAPY	158,159.25	2,822.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	639,332.21	264,683.14	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,909.00	14,165.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	282,216.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	68,992.51	2,795.24	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,915,895.25	33,132.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	96,457.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,526.50	4,173.60
RADIOLOGY THERAPEUTIC	10,808.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	30,518.00	13,458.26	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	684.50	8,282.28	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,321.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	56,378.93	4,380.29	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	9,572.25	65.00	IMPL DEV CHARGE PATIENTS	67,528.25	2,336.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	116,951.00	9,270.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,800.25	1,816.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,530.25	36,357.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	278,056.50	60,963.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	85,294.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	180,720.75	23,849.40			
			TOTAL ANCILLARY	8,374,556.01	652,298.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,374,556.01	652,298.49

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

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

Run Date: 08/29/2018
Run Time: 00:38:04
Page: 7

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	195,431.09	ADJUSTMENTS	0.00
COVERED CHARGES	127,556.44	CONTRACTUAL ALLOW	64,239.54
NON-COVERD CHARGES	67,874.65	TOTAL MEDICAID LIAB	63,316.90
		LESS: COB	63,275.55
		LESS: COPAYMENT	41.35
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,544.05	0.00	OTHER LAB	3,050.00	0.00
MED/SURG SUPPLY	14,987.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,132.00	1,487.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,833.50	12,887.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	185.02	FEE SCHEDULE LAB	28,801.00	2,788.50
EKG/ECG	3,492.00	0.00	MRI SERVICES	0.00	8,197.00
IV THERAPY	4,500.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	952.00	24,422.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	415.50	61.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,619.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,068.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,843.25	1,068.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,395.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,059.66	760.25
RADIOLOGY THERAPEUTIC	346.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	185.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	885.65	516.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	3,668.00	IMPL DEV CHARGE PATIENTS	109.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,329.25	861.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	8,384.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,318.03	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,942.30	333.60			
			TOTAL ANCILLARY	127,556.44	67,874.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	127,556.44	67,874.65

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

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

Run Date: 08/29/2018
Run Time: 00:38:05
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	589,129.94	ADJUSTMENTS	1,120.74
COVERED CHARGES	577,908.69	CONTRACTUAL ALLOW	550,106.51
NON-COVERD CHARGES	11,221.25	TOTAL MEDICAID LIAB	27,802.18
		LESS: COB	0.00
		LESS: COPAYMENT	1,163.55
		REIMBURSEMENT	26,638.63
		TOTAL NUMBER OF CLAIMS	497

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,081.44	0.00	OTHER LAB	1,181.75	0.00
MED/SURG SUPPLY	18,319.25	143.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,594.50	798.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,198.25	3,317.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	131,187.75	4,979.25
EKG/ECG	15,815.00	0.00	MRI SERVICES	2,640.00	0.00
IV THERAPY	11,960.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,397.75	263.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	534.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	261,577.25	1,188.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,250.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	172.25	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	2,802.50	359.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	721.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	648.00	0.00			
			TOTAL ANCILLARY	577,908.69	11,221.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	577,908.69	11,221.25

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: 08/29/2018
Run Time: 00:38:07
Page: 11

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,824.66	ADJUSTMENTS	0.00
COVERED CHARGES	12,539.16	CONTRACTUAL ALLOW	7,818.03
NON-COVERD CHARGES	5,285.50	TOTAL MEDICAID LIAB	4,721.13
		LESS: COB	4,688.13
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	392.66	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	269.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	902.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,359.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,177.75	920.00
EKG/ECG	367.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	362.25	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	6,590.50	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	476.75	6.50
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	12,539.16	5,285.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,539.16	5,285.50

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,502,901.79	ADJUSTMENTS	71,385.28
COVERED CHARGES	2,373,742.09	CONTRACTUAL ALLOW	2,104,459.65
NON-COVERD CHARGES	129,159.70	TOTAL MEDICAID LIAB	269,282.44
		LESS: COB	0.00
		LESS: COPAYMENT	211.12
		REIMBURSEMENT	269,071.32

TOTAL NUMBER OF CLAIMS 49

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	488,277.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	220,812.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,787.25	21,137.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,774.05	FEE SCHEDULE LAB	20,136.25	496.50
EKG/ECG	2,115.00	1,011.00	MRI SERVICES	0.00	0.00
IV THERAPY	557.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	828,223.38	101,745.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,690.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	97,916.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,135.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,318.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,850.00	1,165.00
RADIOLOGY THERAPEUTIC	2,809.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,072.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	778.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	589,156.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,297.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	654.00	660.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	72,662.50	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	3,565.00	98.00			
			TOTAL ANCILLARY	2,373,742.09	129,159.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,373,742.09	129,159.70

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST. FRANCIS HEALTH, LLC
2122 MANCHESTER EXPY
COLUMBUS,GA 31904-6878

PROVIDER NUMBER
000001768A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA
 2260 WRIGHTSBORO RD
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER 000001779A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,180,244.18	ADJUSTMENTS	38,789.65
COVERED CHARGES	3,152,769.35	CONTRACTUAL ALLOW	2,595,310.50
NON-COVERD CHARGES	27,474.83	TOTAL MEDICAID LIAB	557,458.85
		LESS: COB	7,366.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	550,092.66

TOTAL NUMBER OF ADMISSIONS 69

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	167		0	280,894.00		21,219.00
ROUTINE NURSERY	19		0	23,344.00		3,010.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	186		0	304,238.00		24,229.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	64		0	168,847.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	168,847.00		0.00
TOTAL ACCOMODATIONS	250		0	473,085.00		24,229.00

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 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	447,551.88	0.00	OTHER LAB	5,038.79	0.00
MED/SURG SUPPLY	577,097.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	149,042.31	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,373.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,411.64	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	62,252.84	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,002.81	0.00	MRI SERVICES	2,529.21	0.00
IV THERAPY	20,146.67	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	389,642.56	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	98,674.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	89,573.99	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	195,988.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	31,841.15	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	114,092.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	95,533.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,998.03	0.00	INJECTABLE DRUGS	14,115.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	43,775.40	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,543.84	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,784.85	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,231.32	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	119,699.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,662.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,445.32	2,355.88			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,342.32	889.95			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,010.33	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,282.58	0.00			
			TOTAL ANCILLARY	2,679,684.35	3,245.83
			TOTAL ACCOMODATIONS	473,085.00	24,229.00
			TOTAL CHARGES	3,152,769.35	27,474.83

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	10/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,677,253.58	ADJUSTMENTS	235,324.50
COVERED CHARGES	4,061,005.98	CONTRACTUAL ALLOW	3,481,301.37
NON-COVERD CHARGES	616,247.60	TOTAL MEDICAID LIAB	579,704.61
		LESS: COB	1,086.53
		LESS: COPAYMENT	1,078.00
		REIMBURSEMENT	577,540.08
		ALL OTHER	531,550.75
		FEE SCHEDULE-LAB	40,472.21
		INJECTABLE DRUGS	5,517.12

TOTAL NUMBER OF CLAIMS 1,291

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 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	116,677.31	9,197.79	OTHER LAB	66,759.02	0.00
MED/SURG SUPPLY	105,122.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	140,745.03	66,457.32	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	112,996.23	65,506.14	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,837.53	FEE SCHEDULE LAB	357,344.73	14,210.23
EKG/ECG	46,463.56	294.43	MRI SERVICES	20,466.69	0.00
IV THERAPY	298,127.34	9,742.22	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	506,280.07	107,624.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,600.18	9,339.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	296,563.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	188,839.00	30,562.95	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,075,174.86	1,839.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,096.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78,587.48	30,911.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,241.77	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,569.70	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,900.90	2,318.53	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,160.34	154,055.28
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	70,968.52	35,051.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,717.48	8,128.41			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,024.53	22,186.48			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	139,673.41	32,416.58			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	183,716.51	6,756.04			
			TOTAL ANCILLARY	4,061,005.98	616,247.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,061,005.98	616,247.60

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,261.69	ADJUSTMENTS	0.00
COVERED CHARGES	57,146.07	CONTRACTUAL ALLOW	41,833.82
NON-COVERD CHARGES	36,115.62	TOTAL MEDICAID LIAB	15,312.25
		LESS: COB	15,300.25
		LESS: COPAYMENT	12.00
		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

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 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,328.76	201.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,288.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,896.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,666.79	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,482.46	692.00
EKG/ECG	294.43	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,182.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	16,628.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,528.15	4,706.81	AMBULANCE	0.00	0.00
GI SERVICES	3,466.40	901.74	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,143.71	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,392.36	3,637.04	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,053.27	1,524.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	174.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	283.52
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,152.70	699.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	936.33	0.00			
			TOTAL ANCILLARY	57,146.07	36,115.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,146.07	36,115.62

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

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

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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 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	175,176.77	ADJUSTMENTS	264.70
COVERED CHARGES	173,188.90	CONTRACTUAL ALLOW	165,021.66
NON-COVERD CHARGES	1,987.87	TOTAL MEDICAID LIAB	8,167.24
		LESS: COB	0.00
		LESS: COPAYMENT	251.07
		REIMBURSEMENT	7,916.17
		TOTAL NUMBER OF CLAIMS	146

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 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,869.00	75.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,293.71	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,213.93	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,140.22	854.68
EKG/ECG	2,049.69	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,608.29	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	122,751.03	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	3,034.75	330.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,228.28	727.69			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	173,188.90	1,987.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	173,188.90	1,987.87

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: 08/29/2018
Run Time: 00:06:43
Page: 10

TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	06/30/17
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: 08/29/2018
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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TRINITY HOSPITAL OF AUGUSTA
2260 WRIGHTSBORO RD
AUGUSTA,GA 30904-4764

PROVIDER NUMBER
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	624,941.19	ADJUSTMENTS	38,280.98
COVERED CHARGES	464,826.88	CONTRACTUAL ALLOW	426,511.33
NON-COVERD CHARGES	160,114.31	TOTAL MEDICAID LIAB	38,315.55
		LESS: COB	0.00
		LESS: COPAYMENT	34.57
		REIMBURSEMENT	38,280.98

TOTAL NUMBER OF CLAIMS 7

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 10/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,941.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34,454.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,369.22	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,704.49	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,796.96	FEE SCHEDULE LAB	4,893.28	375.69
EKG/ECG	1,472.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,992.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,495.95	58,380.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	727.48	6,398.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,661.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,229.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,155.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,661.12	8,325.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,210.10	84,836.48
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	543.84	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	169,933.32	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,380.00	0.00			
			TOTAL ANCILLARY	464,826.88	160,114.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	464,826.88	160,114.31

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

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

Run Date: 08/29/2018
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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	10/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:08:01
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH
 11705 MERCY BLVD
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER 000001801A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,661,089.61	ADJUSTMENTS	1,566,866.78
COVERED CHARGES	28,036,162.36	CONTRACTUAL ALLOW	21,374,355.42
NON-COVERD CHARGES	624,927.25	TOTAL MEDICAID LIAB	6,661,806.94
		LESS: COB	101,970.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,559,836.47

TOTAL NUMBER OF ADMISSIONS 365

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,365		0	1,294,176.00		104,102.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,365		0	1,294,176.00		104,102.00
SPECIAL CARE SERVICES						
CCU	370		0	1,171,056.00		0.00
ICU	1,642		0	3,598,771.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,012		0	4,769,827.00		0.00
TOTAL ACCOMODATIONS	3,377		0	6,064,003.00		104,102.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,463,433.00	2,323.00	OTHER LAB	129,471.00	0.00
MED/SURG SUPPLY	853,186.00	1,394.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,630,278.00	47,642.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	724,199.00	0.00	OTHER THERAPEUTIC SVC	0.00	44,945.00
CT SCAN	1,030,400.00	37,802.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	284,676.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	70,341.00	0.00	MRI SERVICES	332,934.00	0.00
IV THERAPY	203,542.00	3,337.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,913,049.36	17,146.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,901,445.00	12.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	568,742.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	99,596.00	4,818.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	320,404.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	302,676.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	56,567.00	0.00	INJECTABLE DRUGS	2,750,465.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	106,053.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	132,440.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	469,230.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,291,623.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	73,384.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	382,361.00	140,697.22			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	102,638.00	220,709.00			
AUDIOLOGY	2,217.00	0.00			
CARDIOLOGY	669,770.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,913.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	48,126.00	0.00			
			TOTAL ANCILLARY	21,972,159.36	520,825.25
			TOTAL ACCOMODATIONS	6,064,003.00	104,102.00
			TOTAL CHARGES	28,036,162.36	624,927.25

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

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

Run Date: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
Run Time: 00:08:05
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,273,438.65	ADJUSTMENTS	95,455.81
COVERED CHARGES	7,201,102.53	CONTRACTUAL ALLOW	6,091,230.04
NON-COVERD CHARGES	1,072,336.12	TOTAL MEDICAID LIAB	1,109,872.49
		LESS: COB	7,627.58
		LESS: COPAYMENT	2,282.38
		REIMBURSEMENT	1,099,962.53
		ALL OTHER	1,036,528.36
		FEE SCHEDULE-LAB	63,291.77
		INJECTABLE DRUGS	142.40
		TOTAL NUMBER OF CLAIMS	2,381

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	582,223.08	775.00	OTHER LAB	72,283.00	0.00
MED/SURG SUPPLY	230,727.00	112.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	343,727.00	17,542.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	750,880.00	126,227.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,917.00	10,848.06	FEE SCHEDULE LAB	569,090.00	9,000.00
EKG/ECG	61,306.00	5,010.00	MRI SERVICES	162,404.00	13,063.00
IV THERAPY	694,179.00	9,109.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,025,452.50	141,571.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,257.00	7,481.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	250,914.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	50,050.34	6,691.66	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,116,165.00	11,118.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	137,119.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,221.00	2,589.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,021.00	7,107.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	507.00	2,608.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	25,105.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	157,302.00	220,524.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	106,679.00	13,741.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,605.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	190,228.00	162,772.00			
AUDIOLOGY	95,054.00	50,920.00			
CARDIOLOGY	478,199.09	223,273.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,621.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	63,971.52	5,149.00			
			TOTAL ANCILLARY	7,201,102.53	1,072,336.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,201,102.53	1,072,336.12

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	157,481.50	ADJUSTMENTS	0.00
COVERED CHARGES	117,748.65	CONTRACTUAL ALLOW	73,169.44
NON-COVERD CHARGES	39,732.85	TOTAL MEDICAID LIAB	44,579.21
		LESS: COB	44,546.21
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,969.00	0.00	OTHER LAB	900.00	0.00
MED/SURG SUPPLY	618.00	0.00	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	3,146.00	7,896.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,441.00	645.00
EKG/ECG	334.00	0.00	MRI SERVICES	12,443.00	0.00
IV THERAPY	4,299.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,637.65	16,404.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,997.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,398.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,893.00	1,689.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,005.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	939.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,963.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,100.00	8,016.00			
CARDIOLOGY	0.00	1,077.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,316.00	0.00			
			TOTAL ANCILLARY	117,748.65	39,732.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	117,748.65	39,732.85

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	173,106.00	ADJUSTMENTS	108.88
COVERED CHARGES	162,065.00	CONTRACTUAL ALLOW	154,848.74
NON-COVERD CHARGES	11,041.00	TOTAL MEDICAID LIAB	7,216.26
		LESS: COB	0.00
		LESS: COPAYMENT	306.00
		REIMBURSEMENT	6,910.26
		TOTAL NUMBER OF CLAIMS	129

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,925.00	0.00	OTHER LAB	1,570.00	0.00
MED/SURG SUPPLY	59.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,975.00	1,077.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	9,369.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,215.00	18.00
EKG/ECG	1,336.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	26,412.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,091.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,173.00	577.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	162,065.00	11,041.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	162,065.00	11,041.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,445.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,726.00	CONTRACTUAL ALLOW	2,583.63
NON-COVERD CHARGES	719.00	TOTAL MEDICAID LIAB	1,142.37
		LESS: COB	1,136.37
		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: 08/29/2018
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST JOSEPH'S HOSPITAL SAVANNAH
 11705 MERCY BLVD
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER
 000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 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	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	618.00	36.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,051.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	610.00	683.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,726.00	719.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,726.00	719.00

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 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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,278,823.00	ADJUSTMENTS	59,620.18
COVERED CHARGES	1,114,901.90	CONTRACTUAL ALLOW	1,017,263.06
NON-COVERD CHARGES	163,921.10	TOTAL MEDICAID LIAB	97,638.84
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	97,560.84
		TOTAL NUMBER OF CLAIMS	18

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,148.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	77,013.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,648.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,788.00	0.00
EKG/ECG	835.00	334.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	114,704.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	468.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,594.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,348.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	634,033.00	96,769.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,575.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	136,747.90	66,818.10			
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	0.00	0.00			
			TOTAL ANCILLARY	1,114,901.90	163,921.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,114,901.90	163,921.10

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

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

Run Date: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,835.00	ADJUSTMENTS	5,157.89
COVERED CHARGES	49,325.00	CONTRACTUAL ALLOW	39,336.05
NON-COVERD CHARGES	510.00	TOTAL MEDICAID LIAB	9,988.95
		LESS: COB	1,075.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,913.43

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	13,650.00		510.00
ROUTINE NURSERY	0		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	13,650.00		510.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	13,650.00		510.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,307.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,052.55	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	2,536.13	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	206.96	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,541.20	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	125.28	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,139.05	0.00			
			TOTAL ANCILLARY	35,675.00	0.00
			TOTAL ACCOMODATIONS	13,650.00	510.00
			TOTAL CHARGES	49,325.00	510.00

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

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

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
Run Time: 00:52:01
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,223,275.86	ADJUSTMENTS	51,143.23
COVERED CHARGES	2,156,584.08	CONTRACTUAL ALLOW	1,934,173.24
NON-COVERD CHARGES	66,691.78	TOTAL MEDICAID LIAB	222,410.84
		LESS: COB	205.63
		LESS: COPAYMENT	339.00
		REIMBURSEMENT	221,866.21
		ALL OTHER	203,705.01
		FEE SCHEDULE-LAB	15,928.59
		INJECTABLE DRUGS	2,232.61

TOTAL NUMBER OF CLAIMS 950

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,766.07	795.24	OTHER LAB	6,571.29	0.00
MED/SURG SUPPLY	36,269.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	218,342.29	5,434.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	344,604.46	30,197.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,860.19	3,268.20	FEE SCHEDULE LAB	257,709.35	1,432.54
EKG/ECG	31,531.50	409.50	MRI SERVICES	0.00	0.00
IV THERAPY	73,555.17	2,482.53	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,330.10	5,011.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	955,897.31	217.92	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	80,597.32	8,512.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,494.74	4,207.19	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,954.75	174.30	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,753.92	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,099.62	2,794.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,156,584.08	66,691.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,156,584.08	66,691.78

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
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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WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	334,340.05	ADJUSTMENTS	47.00
COVERED CHARGES	315,329.95	CONTRACTUAL ALLOW	304,829.95
NON-COVERD CHARGES	19,010.10	TOTAL MEDICAID LIAB	10,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	439.39
		REIMBURSEMENT	10,060.61
		TOTAL NUMBER OF CLAIMS	210

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SYLVAN GROVE HOSPITAL, INC
 1050 MCDONOUGH RD
 JACKSON,GA 30233-1524

PROVIDER NUMBER
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,515.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,635.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,137.78	1,187.37	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,237.60	16,233.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,919.17	451.24
EKG/ECG	2,866.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,535.76	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	958.67	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	194,177.44	108.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,345.96	1,029.53
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	315,329.95	19,010.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	315,329.95	19,010.10

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

WELLSTAR SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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	07/01/16	THROUGH	06/30/17
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 SYLVAN GROVE HOSPITAL, INC
1050 MCDONOUGH RD
JACKSON,GA 30233-1524

PROVIDER NUMBER
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL
 247 S MAIN ST
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER 000001878A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,785,017.42	ADJUSTMENTS	11,788.67
COVERED CHARGES	4,601,328.48	CONTRACTUAL ALLOW	4,232,295.35
NON-COVERD CHARGES	183,688.94	TOTAL MEDICAID LIAB	369,033.13
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	369,033.13

TOTAL NUMBER OF ADMISSIONS 41

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	80		4	62,545.00		182,510.84
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	80		4	62,545.00		182,510.84
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	80		4	62,545.00		182,510.84

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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,694.95	0.00	OTHER LAB	11,040.26	0.00
MED/SURG SUPPLY	22,642.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,852.72	0.00	EDUCATION & TRAINING	429.48	0.00
RADIOLOGY-DIAGNOSTIC	6,878.52	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,958.85	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,989.76	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,414.30	0.00	MRI SERVICES	2,878.75	0.00
IV THERAPY	5,338.11	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,619,412.56	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,588.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,887.20	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	1,727.18	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,630,908.72	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	606.48	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,552.00	1,178.10			
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	9,434.31	0.00			
			TOTAL ANCILLARY	4,538,783.48	1,178.10
			TOTAL ACCOMODATIONS	62,545.00	182,510.84
			TOTAL CHARGES	4,601,328.48	183,688.94

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

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 01/01/17 THROUGH 12/31/17
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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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,432,448.36	ADJUSTMENTS	144,986.41
COVERED CHARGES	4,870,713.69	CONTRACTUAL ALLOW	4,320,734.57
NON-COVERD CHARGES	561,734.67	TOTAL MEDICAID LIAB	549,979.12
		LESS: COB	1,156.36
		LESS: COPAYMENT	2,067.00
		REIMBURSEMENT	546,755.76
		ALL OTHER	489,514.64
		FEE SCHEDULE-LAB	57,114.87
		INJECTABLE DRUGS	126.25
		TOTAL NUMBER OF CLAIMS	1,752

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,961.44	0.00	OTHER LAB	52,590.82	500.00
MED/SURG SUPPLY	7,198.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	47.72	95.44
RADIOLOGY-DIAGNOSTIC	91,610.44	5,834.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	231,428.82	36,629.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,015.82	6,937.27	FEE SCHEDULE LAB	514,621.14	28,681.00
EKG/ECG	29,057.60	689.80	MRI SERVICES	174,263.32	7,312.41
IV THERAPY	54,770.91	6,604.35	PROFESSIONAL FEES	0.00	2,167.00
OPERATING ROOM	3,235,837.20	455,252.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,355.29	1,023.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,500.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	229,620.14	1,035.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,367.62	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,154.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	986.48	582.95	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,198.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,511.94	3,910.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,513.40	785.40			
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	17,603.04	2,192.73			
			TOTAL ANCILLARY	4,870,713.69	561,734.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,870,713.69	561,734.67

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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,481.58	ADJUSTMENTS	0.00
COVERED CHARGES	6,819.93	CONTRACTUAL ALLOW	4,434.84
NON-COVERD CHARGES	1,661.65	TOTAL MEDICAID LIAB	2,385.09
		LESS: COB	2,373.09
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	280.00	0.00	OTHER LAB	716.51	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	505.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,503.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,117.76	157.84
EKG/ECG	344.90	0.00	MRI SERVICES	1,946.28	0.00
IV THERAPY	285.84	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,622.84	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	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,819.93	1,661.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,819.93	1,661.65

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

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

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	145,715.98	ADJUSTMENTS	864.00
COVERED CHARGES	134,776.53	CONTRACTUAL ALLOW	127,076.53
NON-COVERD CHARGES	10,939.45	TOTAL MEDICAID LIAB	7,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	291.00
		REIMBURSEMENT	7,409.00
		TOTAL NUMBER OF CLAIMS	154

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,653.67	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	179.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
RADIOLOGY-DIAGNOSTIC	6,352.26	1,112.94	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,421.24	6,967.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,703.36	2,257.28
EKG/ECG	2,414.30	0.00	MRI SERVICES	1,948.38	0.00
IV THERAPY	7,399.28	554.41	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	518.17	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,426.26	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,214.16	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	519.80	0.00			
			TOTAL ANCILLARY	134,776.53	10,939.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	134,776.53	10,939.45

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

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

Run Date: 08/29/2018
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	889.01	ADJUSTMENTS	0.00
COVERED CHARGES	865.01	CONTRACTUAL ALLOW	729.91
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	135.10
		LESS: COB	135.10
		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: 08/29/2018
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL
 247 S MAIN ST
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
 000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	510.40	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	319.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	865.01	24.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	865.01	24.00

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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,337,518.81	ADJUSTMENTS	4,852.70
COVERED CHARGES	1,319,180.80	CONTRACTUAL ALLOW	1,241,489.60
NON-COVERD CHARGES	18,338.01	TOTAL MEDICAID LIAB	77,691.20
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	77,634.20

TOTAL NUMBER OF CLAIMS 16

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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,998.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,888.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	190.88
RADIOLOGY-DIAGNOSTIC	322.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,745.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	866.68	FEE SCHEDULE LAB	964.32	72.00
EKG/ECG	0.00	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	95.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	959,473.52	14,536.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	568.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500.00	2,500.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	319.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,768.79	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	310,536.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,319,180.80	18,338.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,319,180.80	18,338.01

Report : 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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL
247 S MAIN ST
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER
000001878A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR
 901 18TH ST E
 TIFTON,GA 31794-3648

PROVIDER NUMBER 000001922A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,204,470.47	ADJUSTMENTS	447,082.08
COVERED CHARGES	29,684,189.13	CONTRACTUAL ALLOW	22,675,521.54
NON-COVERD CHARGES	520,281.34	TOTAL MEDICAID LIAB	7,008,667.59
		LESS: COB	41,794.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,966,872.67

TOTAL NUMBER OF ADMISSIONS 851

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,742		0	2,472,040.10		204,420.00
ROUTINE NURSERY	195		0	157,980.00		43,610.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,937		0	2,630,020.10		248,030.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,011		0	2,162,440.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,011		0	2,162,440.00		0.00
TOTAL ACCOMODATIONS	3,948		0	4,792,460.10		248,030.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,962,668.21	157.25	OTHER LAB	114,956.48	0.00
MED/SURG SUPPLY	1,605,298.54	8,369.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,611,782.48	0.00	EDUCATION & TRAINING	1,676.26	0.00
RADIOLOGY-DIAGNOSTIC	616,202.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,637,120.63	33,696.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	289,532.01	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	225,494.99	0.00	MRI SERVICES	286,505.17	0.00
IV THERAPY	99,383.10	0.00	PROFESSIONAL FEES	0.00	14,027.05
OPERATING ROOM	1,384,683.14	863.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	185,808.67	0.00	REHAB THERAPY	1,118.50	0.00
RESPIRATORY SERVICES	552,956.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	322,758.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	189,728.09	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,364,525.72	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	172,757.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	110,124.02	0.00	INJECTABLE DRUGS	3,935,985.29	0.00
RADIOLOGY THERAPEUTIC	18,689.11	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	61,608.55	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,548.04	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	74,123.90	3,669.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,857.56	395.96	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	707,103.45	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	148,038.20	0.00			
BLOOD	1,005.67	0.00			
BLOOD STORAGE & PRO.	363,290.33	182,026.27			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	136,048.49	28,770.81			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,085,371.21	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,927.51	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	550,051.63	274.81			
			TOTAL ANCILLARY	24,891,729.03	272,251.34
			TOTAL ACCOMODATIONS	4,792,460.10	248,030.00
			TOTAL CHARGES	29,684,189.13	520,281.34

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

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

Run Date: 08/29/2018
 Run Time: 00:28:15
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	161,559.55	ADJUSTMENTS	0.00
COVERED CHARGES	152,789.02	CONTRACTUAL ALLOW	64,929.92
NON-COVERD CHARGES	8,770.53	TOTAL MEDICAID LIAB	87,859.10
		LESS: COB	87,859.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		0	10,020.00		1,600.00
ROUTINE NURSERY	6		0	5,300.00		4,010.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17		0	15,320.00		5,610.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	17		0	15,320.00		5,610.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,246.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,179.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,106.03	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,840.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,335.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	498.18	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	964.05	0.00	PROFESSIONAL FEES	0.00	3,160.53
OPERATING ROOM	7,294.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,074.59	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,640.77	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,474.91	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,444.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	432.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,619.25	0.00	INJECTABLE DRUGS	24,972.45	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	336.72	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	201.33	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,476.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	708.39	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,525.73	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,096.90	0.00			
			TOTAL ANCILLARY	137,469.02	3,160.53
			TOTAL ACCOMODATIONS	15,320.00	5,610.00
			TOTAL CHARGES	152,789.02	8,770.53

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: 08/29/2018
Run Time: 00:28:16
Page: 5

TIFT REGIONAL MEDICAL CTR
901 18TH ST E
TIFTON,GA 31794-3648

PROVIDER NUMBER
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,602,791.90	ADJUSTMENTS	1,548,807.98
COVERED CHARGES	27,485,151.40	CONTRACTUAL ALLOW	23,307,501.01
NON-COVERD CHARGES	3,117,640.50	TOTAL MEDICAID LIAB	4,177,650.39
		LESS: COB	13,145.45
		LESS: COPAYMENT	12,809.69
		REIMBURSEMENT	4,151,695.25
		ALL OTHER	3,277,818.99
		FEE SCHEDULE-LAB	524,635.39
		INJECTABLE DRUGS	349,240.87
		TOTAL NUMBER OF CLAIMS	10,042

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,814,663.51	82,564.41	OTHER LAB	866,418.48	672.22
MED/SURG SUPPLY	697,064.93	29,899.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	154.99	EDUCATION & TRAINING	0.00	56.00
RADIOLOGY-DIAGNOSTIC	1,140,458.15	31,290.47	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,997,275.42	366,591.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,643.43	26,764.95	FEE SCHEDULE LAB	5,778,438.26	340,501.24
EKG/ECG	225,475.98	6,227.25	MRI SERVICES	717,867.69	66,964.44
IV THERAPY	593,198.43	75,120.32	PROFESSIONAL FEES	0.00	52,635.73
OPERATING ROOM	1,659,206.97	372,175.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	700.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	98,533.57	25,969.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	373,258.85	31,516.77	AMBULANCE	0.00	0.00
GI SERVICES	602,004.68	34,202.63	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,519,643.49	93,411.58	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	327,187.41	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,744,801.21	818,740.60
RADIOLOGY THERAPEUTIC	663,039.60	174,050.37	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,572.70	11,420.26	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,957.39	6,995.78	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,145.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	127,602.96	20,559.02	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	243,806.41	75,190.57
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	176.44	5,916.71
OTHER IMAGING SERVICE	979,484.35	128,596.38			
BLOOD	4,827.19	0.00			
BLOOD STORAGE & PRO.	197,903.55	56,121.08			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	516,551.00	67,020.08			
AUDIOLOGY	10,666.55	1,239.62			
CARDIOLOGY	628,978.46	46,707.40			
AMBULATORY SURGERY	1,404.47	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,266.28	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	883,073.49	51,187.35			
			TOTAL ANCILLARY	27,485,151.40	3,116,610.50
			TOTAL ACCOMODATIONS	0.00	1,030.00
			TOTAL CHARGES	27,485,151.40	3,117,640.50

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016303010582	10/19/16 - 10/19/16	11/07/16	0.00	34.25	0.00	0.00	0.00
2600	5916356000996	10/11/16 - 10/11/16	12/26/16	0.00	135.93	0.00	0.00	0.00
948	5916364000193	11/22/16 - 11/28/16	01/02/17	0.00	277.76	0.00	0.00	0.00
780	2017033000151	01/11/17 - 01/11/17	02/06/17	0.00	34.25	0.00	0.00	0.00
780	2017047007413	02/10/17 - 02/10/17	02/20/17	0.00	34.25	0.00	0.00	0.00
948	2017062007114	11/15/16 - 11/15/16	03/06/17	0.00	277.76	0.00	0.00	0.00
948	5917094001701	02/02/17 - 02/02/17	04/10/17	0.00	138.88	0.00	0.00	0.00
948	2017097000007	03/23/17 - 03/23/17	04/10/17	0.00	138.88	0.00	0.00	0.00
948	2017097000007	03/28/17 - 03/28/17	04/10/17	0.00	138.88	0.00	0.00	0.00
948	2017109076620	02/21/17 - 02/21/17	04/24/17	0.00	138.88	0.00	0.00	0.00
2	2217116009382	12/08/16 - 12/08/16	05/01/17	0.00	277.76	0.00	0.00	0.00
-1	2217116009452	12/20/16 - 12/20/16	05/01/17	0.00	138.88	0.00	0.00	0.00
1	2217116009452	12/15/16 - 12/15/16	05/01/17	0.00	138.88	0.00	0.00	0.00
948	2017174092484	05/18/17 - 05/18/17	07/03/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/01/17 - 06/01/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/02/17 - 06/02/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/06/17 - 06/06/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/08/17 - 06/08/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/13/17 - 06/13/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/15/17 - 06/15/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/22/17 - 06/22/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/27/17 - 06/27/17	07/10/17	0.00	277.76	0.00	0.00	0.00
948	2017188006105	06/30/17 - 06/30/17	07/10/17	0.00	277.76	0.00	0.00	0.00
780	2017241076869	08/23/17 - 08/23/17	11/13/17	34.25	0.00	0.00	0.00	20.52
780	2017248099338	08/30/17 - 08/30/17	11/13/17	34.25	0.00	0.00	0.00	20.52
780	2217250005641	08/09/17 - 08/09/17	11/13/17	34.25	0.00	0.00	0.00	20.52
780	2017280001336	09/21/17 - 09/21/17	11/13/17	39.44	0.00	0.00	0.00	20.52
948	2017280001843	09/05/17 - 09/05/17	10/16/17	0.00	277.76	0.00	0.00	0.00
948	2017280001843	09/14/17 - 09/14/17	10/16/17	0.00	277.76	0.00	0.00	0.00
948	2017280001843	09/19/17 - 09/19/17	10/16/17	0.00	277.76	0.00	0.00	0.00
948	2017280001843	09/21/17 - 09/21/17	10/16/17	0.00	277.76	0.00	0.00	0.00
780	2017312072158	09/27/17 - 09/27/17	11/13/17	34.25	0.00	0.00	0.00	20.52
614	5917318000602	07/26/17 - 07/26/17	11/20/17	0.00	122.83	0.00	0.00	0.00
TOTAL				176.44	5,916.71	0.00	0.00	102.60

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

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

Run Date: 08/29/2018
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Page: 8

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	734,644.62	ADJUSTMENTS	0.00
COVERED CHARGES	518,947.50	CONTRACTUAL ALLOW	83,936.60
NON-COVERD CHARGES	215,697.12	TOTAL MEDICAID LIAB	435,010.90
		LESS: COB	434,819.66
		LESS: COPAYMENT	191.24
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,660.38	2,059.99	OTHER LAB	13,263.46	0.00
MED/SURG SUPPLY	19,987.93	928.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,755.31	1,259.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,349.68	64,704.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	498.77	FEE SCHEDULE LAB	130,168.50	8,544.07
EKG/ECG	3,487.26	249.09	MRI SERVICES	0.00	4,009.12
IV THERAPY	13,868.76	2,052.86	PROFESSIONAL FEES	0.00	71,615.13
OPERATING ROOM	65,440.27	37,046.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	748.59	309.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,929.93	924.04	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,400.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	64,165.12	891.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,277.77	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,633.84	2,582.63
RADIOLOGY THERAPEUTIC	1,178.00	488.89	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,299.92	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,949.56	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	1,893.55	657.92	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,123.58	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,525.37	3,867.19			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,203.75	3,134.48			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,002.81	1,175.77			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,432.07	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,237.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,614.13	1,049.23			
			TOTAL ANCILLARY	518,947.50	215,697.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	518,947.50	215,697.12

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

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

Run Date: 08/29/2018
Run Time: 00:28:51
Page: 10

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	714,455.70	ADJUSTMENTS	2,225.67
COVERED CHARGES	657,222.90	CONTRACTUAL ALLOW	630,255.33
NON-COVERD CHARGES	57,232.80	TOTAL MEDICAID LIAB	26,967.57
		LESS: COB	1,011.41
		LESS: COPAYMENT	1,012.71
		REIMBURSEMENT	24,943.45
		TOTAL NUMBER OF CLAIMS	464

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,075.03	1,898.46	OTHER LAB	1,591.78	0.00
MED/SURG SUPPLY	11,199.49	77.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,130.25	6,133.02	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	140,726.70	27,701.36	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	323.84	FEE SCHEDULE LAB	123,110.14	6,310.52
EKG/ECG	6,227.25	0.00	MRI SERVICES	4,009.12	0.00
IV THERAPY	18,348.77	2,070.70	PROFESSIONAL FEES	0.00	4,391.07
OPERATING ROOM	7,293.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	169.29	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,403.83	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,801.02	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	234,389.68	2,673.04	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,300.37	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,594.19	3,044.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,193.17	2,609.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	265.32	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,962.03	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	792.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,639.50	0.00			
			TOTAL ANCILLARY	657,222.90	57,232.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	657,222.90	57,232.80

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,044.95	ADJUSTMENTS	0.00
COVERED CHARGES	30,035.17	CONTRACTUAL ALLOW	15,910.49
NON-COVERD CHARGES	9,009.78	TOTAL MEDICAID LIAB	14,124.68
		LESS: COB	14,091.68
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,588.06	1.55	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	951.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,438.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	856.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,535.66	137.23
EKG/ECG	249.09	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,252.65	0.00	PROFESSIONAL FEES	0.00	8,612.75
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,465.58	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3.07	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	244.49	258.25
RADIOLOGY THERAPEUTIC	3,619.52	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	869.74	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,960.81	0.00			
			TOTAL ANCILLARY	30,035.17	9,009.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,035.17	9,009.78

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,645,719.03	ADJUSTMENTS	254,883.20
COVERED CHARGES	7,535,413.94	CONTRACTUAL ALLOW	6,658,283.90
NON-COVERD CHARGES	110,305.09	TOTAL MEDICAID LIAB	877,130.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,250.67
		REIMBURSEMENT	875,879.37
		TOTAL NUMBER OF CLAIMS	162

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	136,942.78	5,867.19	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	117,997.13	3,795.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	97.00	0.00
RADIOLOGY-DIAGNOSTIC	5,933.42	8,855.13	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,555.82	1,589.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,471.43	FEE SCHEDULE LAB	130,206.02	7,952.84
EKG/ECG	747.27	249.09	MRI SERVICES	4,009.12	0.00
IV THERAPY	57,115.20	2,876.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	308,124.08	2,127.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416.67	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,580.79	2,878.74	AMBULANCE	0.00	0.00
GI SERVICES	27,644.27	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,660.17	331.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,060.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,892,849.89	23,192.44
RADIOLOGY THERAPEUTIC	449,344.81	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	498.55	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,364.34	6,046.57	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	179,823.00	29,075.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	39.44
OTHER IMAGING SERVICE	9,970.03	1,122.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,402.90	3,134.48			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,130.78	3,252.96			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	66,139.11	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	60,298.76	3,947.56			
			TOTAL ANCILLARY	7,535,413.94	110,305.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,535,413.94	110,305.09

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

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017188006011	06/15/17 - 06/15/17	07/10/17	0.00	39.44	0.00	0.00	0.00
TOTAL				0.00	39.44	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

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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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000001933A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	210,221.99	ADJUSTMENTS	0.00
COVERED CHARGES	196,762.99	CONTRACTUAL ALLOW	96,747.86
NON-COVERD CHARGES	13,459.00	TOTAL MEDICAID LIAB	100,015.13
		LESS: COB	499.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	99,515.68

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	65		0	48,750.00		7,050.00
ROUTINE NURSERY	0		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	48,750.00		7,050.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,200.00		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	1		0	1,200.00		0.00
TOTAL ACCOMODATIONS	66		0	49,950.00		7,050.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,544.50	0.00	OTHER LAB	600.00	0.00
MED/SURG SUPPLY	5,945.00	59.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	31,039.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,630.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,275.00	3,950.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	445.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,485.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,570.00	0.00	PROFESSIONAL FEES	0.00	240.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,300.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,003.54	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,712.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	87.00	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.	3,273.00	2,160.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,675.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,428.95	0.00			
			TOTAL ANCILLARY	146,812.99	6,409.00
			TOTAL ACCOMODATIONS	49,950.00	7,050.00
			TOTAL CHARGES	196,762.99	13,459.00

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

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

Run Date: 08/29/2018
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
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: 08/29/2018
Run Time: 00:52:40
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CHATUGE REGIONAL HOSPITAL
110 SOUTH MAIN STREET
HIAWASSEE,GA 30546-3408

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	369,660.68	ADJUSTMENTS	788.34
COVERED CHARGES	336,967.06	CONTRACTUAL ALLOW	214,001.11
NON-COVERD CHARGES	32,693.62	TOTAL MEDICAID LIAB	122,965.95
		LESS: COB	0.00
		LESS: COPAYMENT	357.00
		REIMBURSEMENT	122,608.95
		ALL OTHER	106,606.22
		FEE SCHEDULE-LAB	15,603.63
		INJECTABLE DRUGS	399.10

TOTAL NUMBER OF CLAIMS 381

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

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,281.00	9,613.00	OTHER LAB	11,450.00	0.00
MED/SURG SUPPLY	870.00	109.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,240.00	275.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,775.00	3,175.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	99,460.85	4,031.00
EKG/ECG	6,015.00	165.00	MRI SERVICES	13,600.00	1,500.00
IV THERAPY	1,320.00	0.00	PROFESSIONAL FEES	0.00	240.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	340.00	645.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,500.00	3,300.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	93,302.37	2,090.62	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,243.50	3,302.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	508.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,815.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,501.00	3,240.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,000.00	175.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,253.34	325.00			
			TOTAL ANCILLARY	336,967.06	32,693.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	336,967.06	32,693.62

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

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

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	732.99	ADJUSTMENTS	0.00
COVERED CHARGES	724.99	CONTRACTUAL ALLOW	253.60
NON-COVERD CHARGES	8.00	TOTAL MEDICAID LIAB	471.39
		LESS: COB	471.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

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

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 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	492.00	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	232.99	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	724.99	8.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	724.99	8.00

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

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

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

PROVIDER NUMBER
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,934.15	ADJUSTMENTS	0.00
COVERED CHARGES	14,724.15	CONTRACTUAL ALLOW	13,124.15
NON-COVERD CHARGES	210.00	TOTAL MEDICAID LIAB	1,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	1,546.00
		TOTAL NUMBER OF CLAIMS	32

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,401.00	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	105.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,280.00	210.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,508.15	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	265.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,724.15	210.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,724.15	210.00

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

PROVIDER NUMBER
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/16	THROUGH	04/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

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

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

PROVIDER NUMBER
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/16	THROUGH	04/30/17
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

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

PROVIDER NUMBER
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/16	THROUGH	04/30/17
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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	922,939.18	ADJUSTMENTS	17,056.77
COVERED CHARGES	883,756.18	CONTRACTUAL ALLOW	507,705.04
NON-COVERD CHARGES	39,183.00	TOTAL MEDICAID LIAB	376,051.14
		LESS: COB	34,076.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	341,974.74

TOTAL NUMBER OF ADMISSIONS 68

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	150		0	112,500.00		15,030.00
ROUTINE NURSERY	20		6	12,600.00		2,400.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	170		6	125,100.00		17,430.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	31		0	40,300.00		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	31		0	40,300.00		0.00
TOTAL ACCOMODATIONS	201		6	165,400.00		17,430.00

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	147,058.00	0.00	OTHER LAB	1,620.00	0.00
MED/SURG SUPPLY	25,442.00	383.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	83,362.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,101.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,160.00
CT SCAN	24,720.00	13,080.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,368.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,075.00	0.00	MRI SERVICES	2,370.00	1,800.00
IV THERAPY	17,460.00	0.00	PROFESSIONAL FEES	0.00	2,250.00
OPERATING ROOM	47,025.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,504.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	118,124.00	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	68,331.43	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	249.90	0.00	INJECTABLE DRUGS	81,580.75	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	153.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,143.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,881.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,700.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,187.00	1,080.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,280.00	0.00			
AUDIOLOGY	2,440.00	0.00			
CARDIOLOGY	9,916.20	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	15,264.40	0.00			
			TOTAL ANCILLARY	718,356.18	21,753.00
			TOTAL ACCOMODATIONS	165,400.00	17,430.00
			TOTAL CHARGES	883,756.18	39,183.00

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

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	05/01/16	THROUGH	04/30/17
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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,030,601.44	ADJUSTMENTS	97,063.55
COVERED CHARGES	1,950,533.24	CONTRACTUAL ALLOW	1,498,900.42
NON-COVERD CHARGES	80,068.20	TOTAL MEDICAID LIAB	451,632.82
		LESS: COB	143.71
		LESS: COPAYMENT	1,269.86
		REIMBURSEMENT	450,219.25
		ALL OTHER	394,214.70
		FEE SCHEDULE-LAB	46,608.14
		INJECTABLE DRUGS	9,396.41
		TOTAL NUMBER OF CLAIMS	1,362

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,417.17	473.00	OTHER LAB	52,728.00	0.00
MED/SURG SUPPLY	2,158.00	3,024.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	160.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	159,328.00	5,662.00	OTHER THERAPEUTIC SVC	0.00	2,033.00
CT SCAN	305,040.00	4,650.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,710.00	3,490.00	FEE SCHEDULE LAB	286,771.77	15,285.00
EKG/ECG	19,680.00	1,025.00	MRI SERVICES	53,310.00	3,600.00
IV THERAPY	12,090.00	480.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	227,696.00	3,250.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	533.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,279.00	2,288.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,850.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,150.00	550.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	476,161.11	5,820.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,225.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	73,662.56	10,480.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	758.00	1,090.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	185.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,142.00	920.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,327.00	1,503.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,154.00	3,780.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,723.00	3,295.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,580.00	4,779.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,728.40	1,500.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,145.73	930.00			
			TOTAL ANCILLARY	1,950,533.24	80,068.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,950,533.24	80,068.20

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

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,361.20	ADJUSTMENTS	0.00
COVERED CHARGES	42,211.20	CONTRACTUAL ALLOW	9,416.58
NON-COVERD CHARGES	17,150.00	TOTAL MEDICAID LIAB	32,794.62
		LESS: COB	32,776.22
		LESS: COPAYMENT	18.40
		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

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,388.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	280.00	93.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,890.00	0.00	OTHER THERAPEUTIC SVC	0.00	150.00
CT SCAN	3,450.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,226.90	266.00
EKG/ECG	205.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,500.00	360.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,900.00	10,611.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	726.00	850.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,987.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	250.00	375.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,300.00	305.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,545.20	1,200.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	830.00	540.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,532.94	2,400.00			
			TOTAL ANCILLARY	42,211.20	17,150.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,211.20	17,150.00

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: 08/29/2018
Run Time: 00:10:35
Page: 8

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,154.44	ADJUSTMENTS	105.88
COVERED CHARGES	99,598.44	CONTRACTUAL ALLOW	93,556.92
NON-COVERD CHARGES	2,556.00	TOTAL MEDICAID LIAB	6,041.52
		LESS: COB	0.00
		LESS: COPAYMENT	235.17
		REIMBURSEMENT	5,806.35
		TOTAL NUMBER OF CLAIMS	108

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,549.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	76.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,411.00	495.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,920.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,935.00	523.00
EKG/ECG	205.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,249.34	480.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,210.00	982.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	653.00	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	540.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	830.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	436.10	0.00			
			TOTAL ANCILLARY	99,598.44	2,556.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	99,598.44	2,556.00

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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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	05/01/16	THROUGH	04/30/17
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: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,629.00	ADJUSTMENTS	5,437.60
COVERED CHARGES	25,629.00	CONTRACTUAL ALLOW	20,188.40
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

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130.00	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	480.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	25,019.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,629.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,629.00	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: 08/29/2018
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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	05/01/16	THROUGH	04/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,864,294.30	ADJUSTMENTS	401,290.35
COVERED CHARGES	3,243,693.69	CONTRACTUAL ALLOW	2,616,634.91
NON-COVERD CHARGES	2,620,600.61	TOTAL MEDICAID LIAB	627,058.78
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	627,058.78

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	258		0	159,900.00		182,982.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	258		0	159,900.00		182,982.00
SPECIAL CARE SERVICES						
CCU	641		0	969,611.00		705,810.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	641		0	969,611.00		705,810.00
TOTAL ACCOMODATIONS	899		0	1,129,511.00		888,792.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371,165.25	522,120.25	OTHER LAB	31,380.00	16,814.00
MED/SURG SUPPLY	90,696.44	94,236.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	280,400.00	178,883.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,016.00	32,307.00	OTHER THERAPEUTIC SVC	0.00	696.00
CT SCAN	47,150.00	20,966.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	76,520.00	83,520.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,834.00	3,129.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	5,899.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,135.00	19,538.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	976,415.00	473,541.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	4,912.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,940.00	776.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	1,352.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	274.00	1,809.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,039.00	23,452.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,883.00	20,692.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	47,904.00	173,652.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	333.00	666.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	27,712.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,168.00	2,335.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,412.00	4,824.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,016.00	2,816.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,470.00	3,253.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,804.00	1,680.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,228.00	10,228.00			
			TOTAL ANCILLARY	2,114,182.69	1,731,808.61
			TOTAL ACCOMODATIONS	1,129,511.00	888,792.00
			TOTAL CHARGES	3,243,693.69	2,620,600.61

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

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

Run Date: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
Run Time: 00:55:30
Page: 4

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,666,793.70	ADJUSTMENTS	35,312.85
COVERED CHARGES	2,467,774.89	CONTRACTUAL ALLOW	1,928,061.06
NON-COVERD CHARGES	199,018.81	TOTAL MEDICAID LIAB	539,713.83
		LESS: COB	7,153.82
		LESS: COPAYMENT	1,497.00
		REIMBURSEMENT	531,063.01
		ALL OTHER	443,907.25
		FEE SCHEDULE-LAB	996.16
		INJECTABLE DRUGS	86,159.60

TOTAL NUMBER OF CLAIMS 496

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,636.25	705.00	OTHER LAB	12,680.00	0.00
MED/SURG SUPPLY	56,915.08	1,012.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	92,167.00	621.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	125,070.00	20,112.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	208,912.00	30,644.00	FEE SCHEDULE LAB	16,320.00	0.00
EKG/ECG	552.00	0.00	MRI SERVICES	175,632.00	9,022.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	488,522.00	91,483.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	298,921.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	168,215.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	342,651.00	12,738.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,010.00	9,879.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	60,337.56	8,564.52
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	77,598.00	4,136.00			
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	4,529.00	3,526.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	294,107.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,467,774.89	199,018.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,467,774.89	199,018.81

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	176,056.73	ADJUSTMENTS	0.00
COVERED CHARGES	155,659.73	CONTRACTUAL ALLOW	73,915.27
NON-COVERD CHARGES	20,397.00	TOTAL MEDICAID LIAB	81,744.46
		LESS: COB	81,729.46
		LESS: COPAYMENT	15.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,302.00	0.00	OTHER LAB	1,584.00	0.00
MED/SURG SUPPLY	3,457.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	621.00	433.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,461.00	0.00	FEE SCHEDULE LAB	3,271.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,904.00	19,020.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,256.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,556.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,679.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,857.60	944.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,405.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,305.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	155,659.73	20,397.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	155,659.73	20,397.00

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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

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	07/01/16	THROUGH	06/30/17
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 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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	435,352.87	ADJUSTMENTS	23,851.92
COVERED CHARGES	425,313.71	CONTRACTUAL ALLOW	365,676.41
NON-COVERD CHARGES	10,039.16	TOTAL MEDICAID LIAB	59,637.30
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	59,625.30

TOTAL NUMBER OF CLAIMS 10

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	07/01/16	THROUGH	06/30/17
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	4,764.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23,134.64	399.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,977.00	0.00	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	759.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,267.00	3,250.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,976.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,134.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	159,624.32	6,052.00
LITHOTRIPSY	73,677.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	425,313.71	10,039.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	425,313.71	10,039.16

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 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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,652.57	ADJUSTMENTS	0.00
COVERED CHARGES	30,279.57	CONTRACTUAL ALLOW	2,920.73
NON-COVERD CHARGES	2,373.00	TOTAL MEDICAID LIAB	27,358.84
		LESS: COB	27,355.84
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	605.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	373.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	2.00	2,373.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,632.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,667.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,279.57	2,373.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,279.57	2,373.00

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
 3131 THOMASVILLE HWY
 MOULTRIE,GA 31776-6925

PROVIDER NUMBER 000002021A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,897,949.81	ADJUSTMENTS	776,551.48
COVERED CHARGES	13,780,575.92	CONTRACTUAL ALLOW	8,918,210.26
NON-COVERD CHARGES	117,373.89	TOTAL MEDICAID LIAB	4,862,365.66
		LESS: COB	27,936.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,834,429.57

TOTAL NUMBER OF ADMISSIONS 617

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,575		0	996,339.00		53,888.00
ROUTINE NURSERY	230		0	125,160.00		252.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		5.00
TOTAL ROUTINE	1,805		0	1,121,499.00		54,145.00
SPECIAL CARE SERVICES						
CCU	589		0	587,942.00		0.00
ICU	372		0	516,601.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	961		0	1,104,543.00		0.00
TOTAL ACCOMODATIONS	2,766		0	2,226,042.00		54,145.00

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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,501,925.54	493.89	OTHER LAB	29,603.00	0.00
MED/SURG SUPPLY	1,056,337.91	5,361.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,927,844.00	1,582.00	EDUCATION & TRAINING	3,895.00	0.00
RADIOLOGY-DIAGNOSTIC	201,478.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	728,917.00	11,301.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	93,642.00	250.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	82,466.00	0.00	MRI SERVICES	91,568.00	0.00
IV THERAPY	202,008.70	877.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	859,456.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	162,346.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,111,976.00	2,211.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	163,093.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	85,309.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	518,571.00	380.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,482.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	43,502.00	0.00	INJECTABLE DRUGS	2,341.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,141.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,928.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	207,801.00	7,575.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	405.00	21,153.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	653,737.45	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	70,383.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	137,096.00	5,488.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	115,702.00	6,557.00			
AUDIOLOGY	13,664.00	0.00			
CARDIOLOGY	161,293.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,740.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	163,882.00	0.00			
			TOTAL ANCILLARY	11,554,533.92	63,228.89
			TOTAL ACCOMODATIONS	2,226,042.00	54,145.00
			TOTAL CHARGES	13,780,575.92	117,373.89

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

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

Run Date: 08/29/2018
 Run Time: 00:30:09
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,767.58	ADJUSTMENTS	0.00
COVERED CHARGES	46,620.58	CONTRACTUAL ALLOW	16,712.74
NON-COVERD CHARGES	147.00	TOTAL MEDICAID LIAB	29,907.84
		LESS: COB	29,907.84
		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	6		0	3,782.00		147.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6		0	3,782.00		147.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	6		0	3,782.00		147.00

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,352.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,560.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,917.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	975.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	648.00	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	8,924.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,847.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	577.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,631.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,108.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	590.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,911.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	568.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,838.58	0.00
			TOTAL ACCOMODATIONS	3,782.00	147.00
			TOTAL CHARGES	46,620.58	147.00

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,708,760.86	ADJUSTMENTS	654,678.30
COVERED CHARGES	9,763,907.78	CONTRACTUAL ALLOW	7,718,809.56
NON-COVERD CHARGES	944,853.08	TOTAL MEDICAID LIAB	2,045,098.22
		LESS: COB	5,067.24
		LESS: COPAYMENT	6,295.41
		REIMBURSEMENT	2,033,735.57
		ALL OTHER	1,572,778.47
		FEE SCHEDULE-LAB	189,063.14
		INJECTABLE DRUGS	271,893.96

TOTAL NUMBER OF CLAIMS 4,745

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

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

Run Date: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	336,793.18	1,635.03	OTHER LAB	71,287.00	0.00
MED/SURG SUPPLY	434,827.62	6,866.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	177.00	EDUCATION & TRAINING	0.00	1,066.00
RADIOLOGY-DIAGNOSTIC	327,643.00	7,513.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,477,176.00	75,041.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,090.00	12,774.21	FEE SCHEDULE LAB	980,164.45	58,875.00
EKG/ECG	104,980.00	1,150.00	MRI SERVICES	241,579.00	11,556.00
IV THERAPY	329,729.00	29,167.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	776,900.34	49,358.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,255.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	154,748.00	41,716.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	148,094.41	0.00	AMBULANCE	0.00	0.00
GI SERVICES	258,673.52	38,103.48	CAST ROOM	0.00	0.00
EMERGENCY ROOM	883,789.00	1,237.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,240.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,339,187.29	436,340.50
RADIOLOGY THERAPEUTIC	29,168.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,639.00	2,447.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,249.97	927.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	347,514.00	28,309.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	56,624.00	50,767.43
LITHOTRIPSY	11,559.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	212,250.00	9,353.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,952.00	3,670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	361,095.00	45,763.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	346,171.00	23,098.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	125,057.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	269,472.00	7,942.00			
			TOTAL ANCILLARY	9,763,907.78	944,853.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,763,907.78	944,853.08

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	235,847.11	ADJUSTMENTS	0.00
COVERED CHARGES	171,486.61	CONTRACTUAL ALLOW	37,047.85
NON-COVERD CHARGES	64,360.50	TOTAL MEDICAID LIAB	134,438.76
		LESS: COB	134,376.23
		LESS: COPAYMENT	62.53
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 64

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,047.25	675.81	OTHER LAB	1,617.00	0.00
MED/SURG SUPPLY	4,686.00	319.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,176.00	2,027.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,569.00	21,126.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,583.00	1,315.00
EKG/ECG	1,150.00	0.00	MRI SERVICES	3,137.00	0.00
IV THERAPY	4,097.00	190.00	PROFESSIONAL FEES	0.00	1,069.00
OPERATING ROOM	5,455.00	5,227.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,568.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,420.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,890.50	23,342.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,399.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,618.86	801.19
RADIOLOGY THERAPEUTIC	194.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,470.00	246.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,861.00	631.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,704.00	763.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,160.00	6,628.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,226.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,243.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	215.00	0.00			
			TOTAL ANCILLARY	171,486.61	64,360.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	171,486.61	64,360.50

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	437,604.12	ADJUSTMENTS	1,282.27
COVERED CHARGES	422,559.68	CONTRACTUAL ALLOW	403,801.54
NON-COVERD CHARGES	15,044.44	TOTAL MEDICAID LIAB	18,758.14
		LESS: COB	0.00
		LESS: COPAYMENT	588.52
		REIMBURSEMENT	18,169.62
		TOTAL NUMBER OF CLAIMS	336

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,483.67	109.80	OTHER LAB	5,189.00	0.00
MED/SURG SUPPLY	13,452.50	247.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,855.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	129,805.00	4,210.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,252.00	4,387.00
EKG/ECG	7,590.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,230.00	380.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,581.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	140,430.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,818.51	2,682.64
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	492.00	1,828.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,659.00	1,200.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,722.00	0.00			
			TOTAL ANCILLARY	422,559.68	15,044.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	422,559.68	15,044.44

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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,136.64	ADJUSTMENTS	0.00
COVERED CHARGES	3,136.64	CONTRACTUAL ALLOW	2,895.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	241.05
		LESS: COB	238.05
		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: 08/29/2018
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,640.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	133.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	152.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43.04	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,136.64	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,136.64	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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	719,379.31	ADJUSTMENTS	92,343.20
COVERED CHARGES	664,850.22	CONTRACTUAL ALLOW	501,307.50
NON-COVERD CHARGES	54,529.09	TOTAL MEDICAID LIAB	163,542.72
		LESS: COB	16,625.53
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	146,728.19

TOTAL NUMBER OF CLAIMS 28

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,948.60	0.00	OTHER LAB	893.00	0.00
MED/SURG SUPPLY	17,554.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	32.00
RADIOLOGY-DIAGNOSTIC	1,338.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,054.00	12,845.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	632.00	FEE SCHEDULE LAB	12,815.00	1,003.00
EKG/ECG	1,150.00	0.00	MRI SERVICES	0.00	3,168.00
IV THERAPY	14,244.00	804.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,205.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,518.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,530.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,296.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,555.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	431,523.02	25,210.09
RADIOLOGY THERAPEUTIC	19,616.00	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	5,728.00	1,909.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,703.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	8,168.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,432.00	758.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,187.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,560.00	0.00			
			TOTAL ANCILLARY	664,850.22	54,529.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	664,850.22	54,529.09

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

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,122.91	ADJUSTMENTS	0.00
COVERED CHARGES	30,052.91	CONTRACTUAL ALLOW	3,908.95
NON-COVERD CHARGES	70.00	TOTAL MEDICAID LIAB	26,143.96
		LESS: COB	26,119.96
		LESS: COPAYMENT	24.00
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	577.00	70.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	27,602.91	0.00
RADIOLOGY THERAPEUTIC	817.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,056.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,052.91	70.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,052.91	70.00

** 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

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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,798,453.30	ADJUSTMENTS	120,938.13
COVERED CHARGES	5,752,675.30	CONTRACTUAL ALLOW	3,980,215.66
NON-COVERD CHARGES	45,778.00	TOTAL MEDICAID LIAB	1,772,459.64
		LESS: COB	31,659.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,740,800.60

TOTAL NUMBER OF ADMISSIONS 219

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	654		0	352,506.00		38,106.00
ROUTINE NURSERY	43		0	15,179.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	697		0	367,685.00		38,106.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	172		0	238,736.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	172		0	238,736.00		0.00
TOTAL ACCOMODATIONS	869		0	606,421.00		38,106.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,148,209.00	0.00	OTHER LAB	17,291.00	0.00
MED/SURG SUPPLY	1,000,362.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	619,861.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,832.00	0.00	OTHER THERAPEUTIC SVC	0.00	3.00
CT SCAN	333,867.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,558.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	29,568.00	0.00	MRI SERVICES	61,713.00	0.00
IV THERAPY	83,592.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	602,805.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,122.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	248,299.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	81,488.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	111,054.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,041.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	728.00	0.00	INJECTABLE DRUGS	6,829.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,115.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,996.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,120.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	6,999.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	343,726.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,501.00	0.00			
BLOOD	4,020.00	0.00			
BLOOD STORAGE & PRO.	15,212.00	670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,956.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	59,140.00	0.00			
AMBULATORY SURGERY	10,792.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	136,457.30	0.00			
			TOTAL ANCILLARY	5,146,254.30	7,672.00
			TOTAL ACCOMODATIONS	606,421.00	38,106.00
			TOTAL CHARGES	5,752,675.30	45,778.00

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

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

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,330,600.63	ADJUSTMENTS	312,343.36
COVERED CHARGES	4,766,336.63	CONTRACTUAL ALLOW	3,721,285.25
NON-COVERD CHARGES	564,264.00	TOTAL MEDICAID LIAB	1,045,051.38
		LESS: COB	3,448.29
		LESS: COPAYMENT	2,123.43
		REIMBURSEMENT	1,039,479.66
		ALL OTHER	937,218.31
		FEE SCHEDULE-LAB	90,202.87
		INJECTABLE DRUGS	12,058.48
		TOTAL NUMBER OF CLAIMS	2,417

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	334,182.00	296.00	OTHER LAB	29,470.00	1,987.00
MED/SURG SUPPLY	574,275.00	326.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	185,959.00	5,502.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	656,334.00	134,308.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,173.00	5,846.00	FEE SCHEDULE LAB	695,508.00	75,714.00
EKG/ECG	64,380.00	6,216.00	MRI SERVICES	120,675.00	20,632.00
IV THERAPY	156,581.00	64,706.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	374,286.00	70,083.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,050.00	297.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,360.00	13,797.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,849.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	638,752.00	3,374.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,190.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161,288.00	60,445.00
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	762.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,920.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27,262.00	1,050.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	909.00	39,363.00
LITHOTRIPSY	144,010.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	85,398.00	18,038.00			
BLOOD	2,010.00	0.00			
BLOOD STORAGE & PRO.	3,040.00	670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	62,905.00	2,993.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	75,396.00	22,509.00			
AMBULATORY SURGERY	1,295.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	205,799.63	13,430.00			
			TOTAL ANCILLARY	4,766,336.63	564,264.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,766,336.63	564,264.00

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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,809.51	ADJUSTMENTS	0.00
COVERED CHARGES	100,623.51	CONTRACTUAL ALLOW	49,237.25
NON-COVERD CHARGES	16,186.00	TOTAL MEDICAID LIAB	51,386.26
		LESS: COB	51,380.26
		LESS: COPAYMENT	6.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,367.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,186.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,119.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,776.00	4,977.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,861.00	2,020.00
EKG/ECG	672.00	168.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,583.00	1,963.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,849.00	1,622.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,188.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,982.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,936.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,856.00	155.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,260.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,492.00	1,289.00
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	1,280.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,303.00	2,042.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	746.00	670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,447.51	0.00			
			TOTAL ANCILLARY	100,623.51	16,186.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	100,623.51	16,186.00

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

WAYNE MEMORIAL HOSPITAL
 865 S 1ST ST
 JESUP,GA 31545-0210

PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00
 000002054A SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	759,674.38	ADJUSTMENTS	2,239.93
COVERED CHARGES	699,602.38	CONTRACTUAL ALLOW	663,968.60
NON-COVERD CHARGES	60,072.00	TOTAL MEDICAID LIAB	35,633.78
		LESS: COB	50.12
		LESS: COPAYMENT	1,280.38
		REIMBURSEMENT	34,303.28

TOTAL NUMBER OF CLAIMS 637

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,677.00	0.00	OTHER LAB	532.00	0.00
MED/SURG SUPPLY	24,187.00	28.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,228.00	233.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,137.00	33,632.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	225.00	FEE SCHEDULE LAB	118,960.00	9,912.00
EKG/ECG	10,752.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	37,079.00	9,559.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,788.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	797.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	286.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	264,099.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	280.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,435.00	933.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,544.00	5,550.00			
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	1,922.00	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	1,899.38	0.00			
			TOTAL ANCILLARY	699,602.38	60,072.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	699,602.38	60,072.00

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

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

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WAYNE MEMORIAL HOSPITAL
865 S 1ST ST
JESUP,GA 31545-0210

PROVIDER NUMBER
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,656.00	ADJUSTMENTS	0.00
COVERED CHARGES	16,434.00	CONTRACTUAL ALLOW	6,754.85
NON-COVERD CHARGES	3,222.00	TOTAL MEDICAID LIAB	9,679.15
		LESS: COB	9,655.15
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	16

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	555.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	592.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	819.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361.00	1,972.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,793.00	470.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	657.00	110.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,985.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	295.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	769.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	608.00	670.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,434.00	3,222.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,434.00	3,222.00

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	516,701.15	ADJUSTMENTS	23,509.32
COVERED CHARGES	485,054.15	CONTRACTUAL ALLOW	390,944.87
NON-COVERD CHARGES	31,647.00	TOTAL MEDICAID LIAB	94,109.28
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	94,037.28

TOTAL NUMBER OF CLAIMS 16

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,867.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	106,693.00	2,006.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,725.00	663.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,676.00	570.00
EKG/ECG	672.00	504.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,011.00	400.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	115,019.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,168.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,316.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	638.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,254.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,554.13	2,238.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,150.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	24,558.00
LITHOTRIPSY	154,575.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	736.02	708.00			
			TOTAL ANCILLARY	485,054.15	31,647.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	485,054.15	31,647.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,887.00	ADJUSTMENTS	0.00
COVERED CHARGES	26,666.00	CONTRACTUAL ALLOW	14,254.29
NON-COVERD CHARGES	221.00	TOTAL MEDICAID LIAB	12,411.71
		LESS: COB	12,408.71
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,143.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,171.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	957.00	221.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,197.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,023.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	994.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	181.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,666.00	221.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,666.00	221.00

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

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

Run Date: 08/29/2018
 Run Time: 00:52:49
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	206,455.00	ADJUSTMENTS	4,966.85
COVERED CHARGES	196,514.00	CONTRACTUAL ALLOW	84,416.04
NON-COVERD CHARGES	9,941.00	TOTAL MEDICAID LIAB	112,097.96
		LESS: COB	3,091.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	109,006.28

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	77		0	38,400.00		8,600.00
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	77		0	38,400.00		8,600.00
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	77		0	38,400.00		8,600.00

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,881.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,589.00	217.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,975.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,868.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,731.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	920.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	570.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,202.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,981.00	1,124.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	536.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,381.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	404.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,420.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,656.00	0.00			
			TOTAL ANCILLARY	158,114.00	1,341.00
			TOTAL ACCOMODATIONS	38,400.00	8,600.00
			TOTAL CHARGES	196,514.00	9,941.00

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 05/01/16 THROUGH 04/30/17
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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	535,317.75	ADJUSTMENTS	28,045.88
COVERED CHARGES	468,080.75	CONTRACTUAL ALLOW	217,595.37
NON-COVERD CHARGES	67,237.00	TOTAL MEDICAID LIAB	250,485.38
		LESS: COB	994.82
		LESS: COPAYMENT	435.00
		REIMBURSEMENT	249,055.56
		ALL OTHER	228,026.11
		FEE SCHEDULE-LAB	19,621.51
		INJECTABLE DRUGS	1,407.94

TOTAL NUMBER OF CLAIMS 638

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

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

Run Date: 08/29/2018
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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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,151.75	740.00	OTHER LAB	6,565.00	0.00
MED/SURG SUPPLY	33,802.00	146.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	20.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,145.00	1,211.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,115.00	2,511.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,230.00	1,101.00	FEE SCHEDULE LAB	96,862.00	8,297.00
EKG/ECG	6,930.00	570.00	MRI SERVICES	3,939.00	0.00
IV THERAPY	0.00	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	12,582.00	5,727.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	148,908.00	37,034.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,144.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,252.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,716.00	1,616.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,695.00	3,420.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,588.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,871.00	4,844.00			
			TOTAL ANCILLARY	468,080.75	67,237.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	468,080.75	67,237.00

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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,691.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,860.00	CONTRACTUAL ALLOW	335.62
NON-COVERD CHARGES	1,831.00	TOTAL MEDICAID LIAB	4,524.38
		LESS: COB	4,524.38
		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

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

PROVIDER NUMBER
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	590.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	692.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	412.00	56.00
EKG/ECG	190.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,744.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	855.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	920.00			
			TOTAL ANCILLARY	4,860.00	1,831.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,860.00	1,831.00

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

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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 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,472.75	ADJUSTMENTS	44.00
COVERED CHARGES	39,730.75	CONTRACTUAL ALLOW	35,862.75
NON-COVERD CHARGES	2,742.00	TOTAL MEDICAID LIAB	3,868.00
		LESS: COB	0.00
		LESS: COPAYMENT	159.00
		REIMBURSEMENT	3,709.00
		TOTAL NUMBER OF CLAIMS	78

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 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,128.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,748.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,576.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,899.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,363.00	330.00
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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	471.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,256.00	2,412.00	SPECIAL SERVICES	0.00	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	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	134.00	0.00			
			TOTAL ANCILLARY	39,730.75	2,742.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,730.75	2,742.00

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

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

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

PROVIDER NUMBER
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/16	THROUGH	04/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

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

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

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 05/01/16 THROUGH 04/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,071.00	ADJUSTMENTS	4,862.89
COVERED CHARGES	11,043.00	CONTRACTUAL ALLOW	6,180.11
NON-COVERD CHARGES	28.00	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

WILLS MEMORIAL HOSPITAL
 120 GORDON ST
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 05/01/16 THROUGH 04/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,568.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	108.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	14.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	211.00	14.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,316.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	840.00	0.00			
			TOTAL ANCILLARY	11,043.00	28.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,043.00	28.00

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

WILLS MEMORIAL HOSPITAL
120 GORDON ST
WASHINGTON,GA 30673-1602

PROVIDER NUMBER
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/16	THROUGH	04/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NGMC BARROW, LLC
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER 000002098A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,168,070.39	ADJUSTMENTS	39,517.26
COVERED CHARGES	3,082,365.85	CONTRACTUAL ALLOW	2,236,667.29
NON-COVERD CHARGES	85,704.54	TOTAL MEDICAID LIAB	845,698.56
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	845,698.56

TOTAL NUMBER OF ADMISSIONS 105

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	110		0	76,772.00		46,240.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	110		0	76,772.00		46,240.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	201		0	346,455.62		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	201		0	346,455.62		0.00
TOTAL ACCOMODATIONS	311		0	423,227.62		46,240.00

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 01/01/17 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	503,855.39	0.00	OTHER LAB	19,429.74	0.00
MED/SURG SUPPLY	107,938.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	423,736.81	0.00	EDUCATION & TRAINING	2,478.80	0.00
RADIOLOGY-DIAGNOSTIC	31,287.75	0.00	OTHER THERAPEUTIC SVC	0.00	3,760.00
CT SCAN	258,479.39	3,732.02	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,067.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	27,907.03	0.00	MRI SERVICES	10,513.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	207,716.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	291,136.14	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,203.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,439.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	276,268.43	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,515.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,211.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,133.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	321.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	163,764.11	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,018.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,826.22	31,266.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,342.00	706.52			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	70,551.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,659,138.23	39,464.54
			TOTAL ACCOMODATIONS	423,227.62	46,240.00
			TOTAL CHARGES	3,082,365.85	85,704.54

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 01/01/17 THROUGH 09/30/17
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: 08/29/2018
Run Time: 00:09:03
Page: 4

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 01/01/17 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,393,255.88	ADJUSTMENTS	62,697.70
COVERED CHARGES	4,498,854.78	CONTRACTUAL ALLOW	4,124,873.22
NON-COVERD CHARGES	894,401.10	TOTAL MEDICAID LIAB	373,981.56
		LESS: COB	450.65
		LESS: COPAYMENT	985.12
		REIMBURSEMENT	372,545.79
		ALL OTHER	317,448.89
		FEE SCHEDULE-LAB	48,614.25
		INJECTABLE DRUGS	6,482.65
		TOTAL NUMBER OF CLAIMS	1,390

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

NGMC BARROW, LLC
 316 N BROAD ST
 WINDER,GA 30680-2150

PROVIDER NUMBER
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,418.45	60,346.28	OTHER LAB	36,599.00	0.00
MED/SURG SUPPLY	49,408.65	2,636.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	294.00	EDUCATION & TRAINING	0.00	1,363.34
RADIOLOGY-DIAGNOSTIC	180,485.50	38,705.50	OTHER THERAPEUTIC SVC	0.00	252.00
CT SCAN	605,784.48	388,024.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,516.00	2,818.00	FEE SCHEDULE LAB	551,135.42	27,584.68
EKG/ECG	60,979.00	578.00	MRI SERVICES	128,138.14	31,937.15
IV THERAPY	17,972.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	242,430.19	95,724.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76,150.46	23,574.28	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	186,376.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	44,904.00	24,534.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,331,247.75	21,121.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	378,485.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	194,778.23	39,636.61
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,433.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,890.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,461.77	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,829.47	5,084.94
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,710.07	12,802.38			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,874.22	6,948.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,477.00	66,293.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,400.00	33,813.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	276,755.75	4,545.00			
			TOTAL ANCILLARY	4,498,854.78	894,401.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,498,854.78	894,401.10

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

Run Date: 08/29/2018
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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 01/01/17 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,845.55	ADJUSTMENTS	0.00
COVERED CHARGES	30,890.24	CONTRACTUAL ALLOW	22,834.69
NON-COVERD CHARGES	5,955.31	TOTAL MEDICAID LIAB	8,055.55
		LESS: COB	8,055.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/17 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27.00	106.19	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	384.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,426.00	971.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,176.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,983.00	408.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,272.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	199.00	293.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,244.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,679.21	1.12
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	2,676.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,890.24	5,955.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,890.24	5,955.31

Report : CLM-0808-0
Process : CLMJ0800
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: 08/29/2018
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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 01/01/17 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	579,531.22	ADJUSTMENTS	700.22
COVERED CHARGES	506,646.17	CONTRACTUAL ALLOW	493,500.27
NON-COVERD CHARGES	72,885.05	TOTAL MEDICAID LIAB	13,145.90
		LESS: COB	0.00
		LESS: COPAYMENT	522.00
		REIMBURSEMENT	12,623.90
		TOTAL NUMBER OF CLAIMS	235

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 01/01/17 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.77	3,037.23	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,287.92	990.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,428.00	5,078.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	87,974.72	47,511.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,511.67	2,999.00
EKG/ECG	6,069.00	289.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	5,553.00	718.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	268,671.99	675.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,745.10	382.68
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	3,569.00	2,163.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,441.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,550.00	2,601.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,584.00	0.00			
			TOTAL ANCILLARY	506,646.17	72,885.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	506,646.17	72,885.05

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

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 01/01/17 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,350.26	ADJUSTMENTS	0.00
COVERED CHARGES	3,245.00	CONTRACTUAL ALLOW	1,697.68
NON-COVERD CHARGES	105.26	TOTAL MEDICAID LIAB	1,547.32
		LESS: COB	1,541.32
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 01/01/17 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	105.14	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	354.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,874.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17.00	0.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,245.00	105.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,245.00	105.26

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

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 01/01/17 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	247,724.12	ADJUSTMENTS	16,321.80
COVERED CHARGES	215,838.65	CONTRACTUAL ALLOW	199,516.85
NON-COVERD CHARGES	31,885.47	TOTAL MEDICAID LIAB	16,321.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,321.80

TOTAL NUMBER OF CLAIMS 3

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 01/01/17 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	857.22	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,797.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	773.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,306.00	2,088.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	738.00	35.00
EKG/ECG	289.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,300.00	11,258.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,567.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,931.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,381.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,296.27	17,647.05
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	47,459.92	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	215,838.65	31,885.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	215,838.65	31,885.47

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

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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	01/01/17	THROUGH	09/30/17
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: 00:53:22
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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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	158,050.99	ADJUSTMENTS	3,739.05
COVERED CHARGES	152,384.99	CONTRACTUAL ALLOW	55,312.79
NON-COVERD CHARGES	5,666.00	TOTAL MEDICAID LIAB	97,072.20
		LESS: COB	747.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	96,325.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	58		5	31,217.00		5,123.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	58		5	31,217.00		5,123.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	58		5	31,217.00		5,123.00

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,030.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,134.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,073.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,567.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,486.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	926.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,454.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	421.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,893.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	455.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,114.00	543.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,614.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	121,167.99	543.00
			TOTAL ACCOMODATIONS	31,217.00	5,123.00
			TOTAL CHARGES	152,384.99	5,666.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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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	08/01/16	THROUGH	07/31/17
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: 08/29/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,470,593.89	ADJUSTMENTS	36,899.97
COVERED CHARGES	1,375,628.59	CONTRACTUAL ALLOW	966,859.86
NON-COVERD CHARGES	94,965.30	TOTAL MEDICAID LIAB	408,768.73
		LESS: COB	74.62
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	408,451.11
		ALL OTHER	370,292.20
		FEE SCHEDULE-LAB	35,208.91
		INJECTABLE DRUGS	2,950.00

TOTAL NUMBER OF CLAIMS 1,349

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,390.44	176.82	OTHER LAB	2,369.00	0.00
MED/SURG SUPPLY	27,944.00	284.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	81,094.00	775.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	243,549.00	30,652.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	914.00	55.00	FEE SCHEDULE LAB	359,094.25	23,971.00
EKG/ECG	18,563.00	1,250.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,950.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,192.00	10,661.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,839.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	514,377.00	3,232.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,592.54	20,469.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,759.00	1,382.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,953.00	1,923.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,228.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,246.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,574.36	134.00			
			TOTAL ANCILLARY	1,375,628.59	94,965.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,375,628.59	94,965.30

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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER
807 S ISABELLA ST
SYLVESTER,GA 31791-7554

PROVIDER NUMBER
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,034.15	ADJUSTMENTS	0.00
COVERED CHARGES	15,715.15	CONTRACTUAL ALLOW	3,557.10
NON-COVERD CHARGES	2,319.00	TOTAL MEDICAID LIAB	12,158.05
		LESS: COB	12,158.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	251.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	403.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	485.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,486.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,707.00	132.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,426.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	433.86	6.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	695.00	695.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,715.15	2,319.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,715.15	2,319.00

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: 08/29/2018
Run Time: 00:53:25
Page: 8

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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,608.52	ADJUSTMENTS	141.00
COVERED CHARGES	52,790.52	CONTRACTUAL ALLOW	49,690.52
NON-COVERD CHARGES	1,818.00	TOTAL MEDICAID LIAB	3,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	2,998.00
		TOTAL NUMBER OF CLAIMS	62

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,448.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	884.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,319.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,201.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,588.00	460.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64.00	235.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,022.55	1,123.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	63.00	0.00			
			TOTAL ANCILLARY	52,790.52	1,818.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,790.52	1,818.00

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: 08/29/2018
Run Time: 00:53:25
Page: 10

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	08/01/16	THROUGH	07/31/17
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: 08/29/2018
Run Time: 00:53:26
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,618.01	ADJUSTMENTS	5,049.93
COVERED CHARGES	34,585.01	CONTRACTUAL ALLOW	29,535.08
NON-COVERD CHARGES	33.00	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

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	258.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	78.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	213.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,486.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	683.00	33.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	981.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,686.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,949.45	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	34,585.01	33.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,585.01	33.00

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

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	08/01/16	THROUGH	07/31/17
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: 08/29/2018
 Run Time: 00:09:21
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER 000020677A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,642,693.57	ADJUSTMENTS	182,299.03
COVERED CHARGES	8,597,527.00	CONTRACTUAL ALLOW	6,628,925.77
NON-COVERD CHARGES	45,166.57	TOTAL MEDICAID LIAB	1,968,601.23
		LESS: COB	19,961.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,948,639.24

TOTAL NUMBER OF ADMISSIONS 243

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	293		0	203,006.18		5,236.05
ROUTINE NURSERY	57		0	20,035.75		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	350		0	223,041.93		5,236.05
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	456		1	591,465.09		925.15
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	456		1	591,465.09		925.15
TOTAL ACCOMODATIONS	806		1	814,507.02		6,161.20

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,175,576.55	0.00	OTHER LAB	90,550.42	0.00
MED/SURG SUPPLY	227,105.57	610.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,318,988.82	0.00	EDUCATION & TRAINING	1,528.46	0.00
RADIOLOGY-DIAGNOSTIC	233,810.01	0.00	OTHER THERAPEUTIC SVC	0.00	8,515.00
CT SCAN	754,957.43	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,662.99	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	143,917.70	0.00	MRI SERVICES	133,465.53	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	669,472.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,565.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	714,395.54	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	433,558.58	0.00	AMBULANCE	0.00	0.00
GI SERVICES	37,265.18	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	787,300.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	128,258.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,966.93	0.00	INJECTABLE DRUGS	3,315.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	38,165.39	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,956.80	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	26,848.77	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,106.63	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,610.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	92,823.94	0.00			
BLOOD	3,464.22	0.00			
BLOOD STORAGE & PRO.	37,423.98	27,264.34			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	77,379.18	2,615.81			
AUDIOLOGY	4,952.53	0.00			
CARDIOLOGY	478,387.88	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,784.74	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,452.54	0.00			
			TOTAL ANCILLARY	7,783,019.98	39,005.37
			TOTAL ACCOMODATIONS	814,507.02	6,161.20
			TOTAL CHARGES	8,597,527.00	45,166.57

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,782.03	ADJUSTMENTS	0.00
COVERED CHARGES	72,782.03	CONTRACTUAL ALLOW	62,960.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,821.20
		LESS: COB	9,821.20
		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	0		0	0.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	0		0	0.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,870.53		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,870.53		0.00
TOTAL ACCOMODATIONS	2		0	2,870.53		0.00

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,558.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,288.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,249.51	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	690.22	0.00	OTHER THERAPEUTIC SVC	0.00	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	36,875.07	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,926.53	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,939.38	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,905.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,478.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	69,911.50	0.00
			TOTAL ACCOMODATIONS	2,870.53	0.00
			TOTAL CHARGES	72,782.03	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: 08/29/2018
Run Time: 00:09:24
Page: 5

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,227,351.85	ADJUSTMENTS	722,886.80
COVERED CHARGES	15,198,855.24	CONTRACTUAL ALLOW	13,738,232.06
NON-COVERD CHARGES	1,028,496.61	TOTAL MEDICAID LIAB	1,460,623.18
		LESS: COB	3,712.44
		LESS: COPAYMENT	3,303.00
		REIMBURSEMENT	1,453,607.74
		ALL OTHER	1,313,928.99
		FEE SCHEDULE-LAB	116,492.86
		INJECTABLE DRUGS	23,185.89

TOTAL NUMBER OF CLAIMS 3,817

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	324,543.51	62,420.47	OTHER LAB	167,677.37	1,218.56
MED/SURG SUPPLY	197,073.30	9,584.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	240.72	EDUCATION & TRAINING	0.00	381.21
RADIOLOGY-DIAGNOSTIC	737,850.66	8,451.76	OTHER THERAPEUTIC SVC	0.00	91,969.80
CT SCAN	1,984,378.62	302,873.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	96,621.00	4,116.91	FEE SCHEDULE LAB	1,736,963.20	74,787.37
EKG/ECG	310,002.29	7,944.67	MRI SERVICES	265,525.48	5,088.19
IV THERAPY	11,377.14	2,119.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	636,654.19	52,616.87	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	161,787.21	69,175.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	487,061.08	26,568.37	AMBULANCE	0.00	0.00
GI SERVICES	231,280.91	8,999.37	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,745,085.05	58,470.43	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	330,039.96	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	393,159.21	52,764.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,531.37	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,282.32	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	5,484.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,448.52	33,618.70
LITHOTRIPSY	52,208.90	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	267,263.20	43,732.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,075.00	10,806.84			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	158,097.17	35,690.29			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	251,658.44	21,967.91			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,784.74	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	620,239.09	26,590.57			
			TOTAL ANCILLARY	15,198,855.24	1,028,496.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,198,855.24	1,028,496.61

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

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	211,839.76	ADJUSTMENTS	0.00
COVERED CHARGES	162,414.86	CONTRACTUAL ALLOW	97,912.04
NON-COVERD CHARGES	49,424.90	TOTAL MEDICAID LIAB	64,502.82
		LESS: COB	64,493.63
		LESS: COPAYMENT	9.19
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 48

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	793.86	8,096.44	OTHER LAB	3,252.24	0.00
MED/SURG SUPPLY	1,392.28	218.43	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,800.43	483.10	OTHER THERAPEUTIC SVC	0.00	1,831.59
CT SCAN	0.00	8,215.51	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,868.95	1,334.27
EKG/ECG	2,450.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	357.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,808.78	15,997.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,704.74	423.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,651.82	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,071.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,156.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,333.72	214.25
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	2,455.65
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,453.73	7,642.65			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,317.56	2,512.04			
			TOTAL ANCILLARY	162,414.86	49,424.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	162,414.86	49,424.90

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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PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,501,524.57	ADJUSTMENTS	2,308.86
COVERED CHARGES	1,399,835.56	CONTRACTUAL ALLOW	1,371,528.46
NON-COVERD CHARGES	101,689.01	TOTAL MEDICAID LIAB	28,307.10
		LESS: COB	0.00
		LESS: COPAYMENT	1,003.36
		REIMBURSEMENT	27,303.74
		TOTAL NUMBER OF CLAIMS	513

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,478.91	15,210.68	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,595.30	452.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,264.27	0.00	OTHER THERAPEUTIC SVC	0.00	2,590.56
CT SCAN	178,140.32	37,561.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	148,657.61	6,759.44
EKG/ECG	21,209.11	605.11	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,473.00	11,578.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,859.75	2,183.48	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,559.88	6,943.01	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	863,592.26	4,460.58	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,365.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,558.32	4,408.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,714.90	8,934.86			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,366.24	0.00			
			TOTAL ANCILLARY	1,399,835.56	101,689.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,399,835.56	101,689.01

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 WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,131.38	ADJUSTMENTS	0.00
COVERED CHARGES	39,091.09	CONTRACTUAL ALLOW	26,414.24
NON-COVERD CHARGES	1,040.29	TOTAL MEDICAID LIAB	12,676.85
		LESS: COB	12,667.85
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.25	57.02	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,568.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,148.75	38.76
EKG/ECG	1,210.22	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	973.29	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,173.15	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	142.59	35.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	756.11	909.50			
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	39,091.09	1,040.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,091.09	1,040.29

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	312,493.09	ADJUSTMENTS	21,750.40
COVERED CHARGES	308,771.46	CONTRACTUAL ALLOW	281,568.46
NON-COVERD CHARGES	3,721.63	TOTAL MEDICAID LIAB	27,203.00
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	27,188.00

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
 2151 W SPRING ST
 MONROE,GA 30655-3115

PROVIDER NUMBER
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,324.45	362.49	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,505.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,069.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,719.82	29.26
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	100,762.70	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	52,181.02	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,753.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,409.23	1,098.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	627.61	2,228.32
LITHOTRIPSY	104,417.80	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	308,771.46	3,721.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	308,771.46	3,721.63

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: 08/29/2018
Run Time: 00:09:54
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT WALTON HOSPITAL, INC
2151 W SPRING ST
MONROE,GA 30655-3115

PROVIDER NUMBER
000020677A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER 000081232A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 08/18/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,644.89	ADJUSTMENTS	0.00
COVERED CHARGES	142,369.89	CONTRACTUAL ALLOW	102,332.80
NON-COVERD CHARGES	275.00	TOTAL MEDICAID LIAB	40,037.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	40,037.09

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	17		0	11,305.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17		0	11,305.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	5,870.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,870.00		0.00
TOTAL ACCOMODATIONS	22		0	17,175.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 08/18/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,682.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,069.09	275.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,078.00	0.00	EDUCATION & TRAINING	50.00	0.00
RADIOLOGY-DIAGNOSTIC	1,593.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,765.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,314.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	824.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,468.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,809.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,249.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,263.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	191.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,626.28	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	27,007.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,206.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	125,194.89	275.00
			TOTAL ACCOMODATIONS	17,175.00	0.00
			TOTAL CHARGES	142,369.89	275.00

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

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	08/18/16
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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DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 08/18/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	191,724.46	ADJUSTMENTS	2,913.17
COVERED CHARGES	181,240.46	CONTRACTUAL ALLOW	146,904.25
NON-COVERD CHARGES	10,484.00	TOTAL MEDICAID LIAB	34,336.21
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	34,222.21
		ALL OTHER	31,457.96
		FEE SCHEDULE-LAB	2,476.79
		INJECTABLE DRUGS	287.46

TOTAL NUMBER OF CLAIMS 79

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 08/18/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,022.00	371.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,092.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	50.00
RADIOLOGY-DIAGNOSTIC	6,587.00	266.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,775.00	1,811.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,310.00	627.00
EKG/ECG	2,258.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,296.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,376.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,160.00	464.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,354.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,627.00	110.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	573.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,217.00	1,259.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	137.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,577.00	3,900.00	IMPL DEV CHARGE PATIENTS	6,569.53	829.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,822.00	660.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	624.00	0.00			
			TOTAL ANCILLARY	181,240.46	10,484.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	181,240.46	10,484.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 08/18/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,377.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,001.00	CONTRACTUAL ALLOW	306.05
NON-COVERD CHARGES	376.00	TOTAL MEDICAID LIAB	694.95
		LESS: COB	694.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 08/18/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	458.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	534.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	376.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,001.00	376.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,001.00	376.00

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

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 08/18/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,897.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,384.00	CONTRACTUAL ALLOW	10,824.60
NON-COVERD CHARGES	513.00	TOTAL MEDICAID LIAB	559.40
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	544.40
		TOTAL NUMBER OF CLAIMS	10

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 08/18/16
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	933.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	568.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	556.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,680.00	57.00
EKG/ECG	206.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,195.00	438.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	752.00	18.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	494.00	0.00			
			TOTAL ANCILLARY	11,384.00	513.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,384.00	513.00

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

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 08/18/16
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,046.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,027.00	CONTRACTUAL ALLOW	424.50
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	602.50
		LESS: COB	602.50
		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

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 08/18/16
 ADMISSION DATES 00/00/00 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	377.00	19.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	650.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,027.00	19.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,027.00	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

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	08/18/16
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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	08/18/16
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER 000081232A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/19/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	523,436.25	ADJUSTMENTS	27,826.56
COVERED CHARGES	519,092.25	CONTRACTUAL ALLOW	354,024.29
NON-COVERD CHARGES	4,344.00	TOTAL MEDICAID LIAB	165,067.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	165,067.96

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	44		0	29,260.00		3,516.00
ROUTINE NURSERY	0		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	29,260.00		3,516.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	15		0	16,160.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	15		0	16,160.00		0.00
TOTAL ACCOMODATIONS	59		0	45,420.00		3,516.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/19/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,236.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	24,467.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	71,655.00	0.00	EDUCATION & TRAINING	160.00	0.00
RADIOLOGY-DIAGNOSTIC	8,763.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,938.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,778.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,914.00	0.00	MRI SERVICES	1,169.00	0.00
IV THERAPY	3,496.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,628.00	828.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,284.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,415.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,639.00	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	90.00	0.00	INJECTABLE DRUGS	77,905.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	250.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,576.51	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,795.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	804.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,990.00	0.00			
			TOTAL ANCILLARY	473,672.25	828.00
			TOTAL ACCOMODATIONS	45,420.00	3,516.00
			TOTAL CHARGES	519,092.25	4,344.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/19/16	THROUGH	06/30/17
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: 08/29/2018
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DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/19/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,167,370.04	ADJUSTMENTS	40,397.89
COVERED CHARGES	1,049,541.46	CONTRACTUAL ALLOW	858,902.95
NON-COVERD CHARGES	117,828.58	TOTAL MEDICAID LIAB	190,638.51
		LESS: COB	45.66
		LESS: COPAYMENT	608.81
		REIMBURSEMENT	189,984.04
		ALL OTHER	168,660.44
		FEE SCHEDULE-LAB	19,243.49
		INJECTABLE DRUGS	2,080.11

TOTAL NUMBER OF CLAIMS 539

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/19/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,105.00	19,939.00	OTHER LAB	4,362.00	0.00
MED/SURG SUPPLY	47,868.13	641.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	97.00	EDUCATION & TRAINING	0.00	150.00
RADIOLOGY-DIAGNOSTIC	53,635.00	5,063.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	189,063.00	22,012.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	231,635.66	7,828.00
EKG/ECG	15,038.00	618.00	MRI SERVICES	7,287.00	0.00
IV THERAPY	12,800.00	175.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,488.00	2,186.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,494.00	2,887.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,382.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	236,141.00	1,320.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,292.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,826.00	19,751.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	648.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	14,583.00	12,932.00	IMPL DEV CHARGE PATIENTS	11,544.67	17,030.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,526.00	3,031.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,206.00	421.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,385.00	370.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	729.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,880.00	0.00			
			TOTAL ANCILLARY	1,049,541.46	117,828.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,049,541.46	117,828.58

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/19/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,127.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,413.00	CONTRACTUAL ALLOW	4,526.06
NON-COVERD CHARGES	13,714.00	TOTAL MEDICAID LIAB	10,886.94
		LESS: COB	10,838.94
		LESS: COPAYMENT	48.00
		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

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/19/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	190.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	237.00	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	2,157.00	9,091.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,076.00	76.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,652.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	365.00	104.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,094.00	4,443.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	94.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,413.00	13,714.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,413.00	13,714.00

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: 08/29/2018
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DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/19/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,071.00	ADJUSTMENTS	105.88
COVERED CHARGES	32,207.00	CONTRACTUAL ALLOW	30,164.16
NON-COVERD CHARGES	2,864.00	TOTAL MEDICAID LIAB	2,042.84
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	1,982.84
		TOTAL NUMBER OF CLAIMS	37

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/19/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126.00	1,178.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	673.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,530.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,731.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,505.00	922.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,512.00	548.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,470.00	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	660.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,207.00	2,864.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,207.00	2,864.00

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: 08/29/2018
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Page: 10

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/19/16	THROUGH	06/30/17
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: 08/29/2018
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/19/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,791.00	ADJUSTMENTS	5,512.23
COVERED CHARGES	46,799.00	CONTRACTUAL ALLOW	35,708.54
NON-COVERD CHARGES	1,992.00	TOTAL MEDICAID LIAB	11,090.46
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	11,054.46
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DURALL CAPITAL HOLDINGS, LLC
 227 MOUNTAIN DR
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/19/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,200.00	1,785.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	587.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,103.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	287.00	57.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,045.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,900.00	150.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,677.00	0.00			
			TOTAL ANCILLARY	46,799.00	1,992.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,799.00	1,992.00

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: 08/29/2018
Run Time: 00:58:59
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DURALL CAPITAL HOLDINGS, LLC
227 MOUNTAIN DR
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/19/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:45:25
 Page: 1

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,156,492.79	ADJUSTMENTS	131,365.68
COVERED CHARGES	3,135,698.94	CONTRACTUAL ALLOW	2,631,205.10
NON-COVERD CHARGES	20,793.85	TOTAL MEDICAID LIAB	504,493.84
		LESS: COB	8,291.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	496,202.38

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	145		7	154,224.67		12,244.57
ROUTINE NURSERY	81		0	62,748.94		1,715.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	226		7	216,973.61		13,960.07
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	61		0	92,554.92		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	61		0	92,554.92		0.00
TOTAL ACCOMODATIONS	287		7	309,528.53		13,960.07

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
 Run Time: 00:45:25
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313,377.85	0.00	OTHER LAB	4,635.91	0.00
MED/SURG SUPPLY	96,815.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	500,345.36	0.00	EDUCATION & TRAINING	708.64	0.00
RADIOLOGY-DIAGNOSTIC	19,770.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,186.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,984.31	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,544.23	0.00	MRI SERVICES	4,805.94	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	402,040.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	355,438.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	82,374.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,822.87	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	105,266.24	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,650.09	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,654.70	0.00	INJECTABLE DRUGS	612,273.61	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,499.43	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,454.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,519.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,084.02	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,857.94	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,707.96	6,719.37			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,564.12	114.41			
AUDIOLOGY	8,179.48	0.00			
CARDIOLOGY	15,074.26	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	5,533.95	0.00			
			TOTAL ANCILLARY	2,826,170.41	6,833.78
			TOTAL ACCOMODATIONS	309,528.53	13,960.07
			TOTAL CHARGES	3,135,698.94	20,793.85

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,697.72	ADJUSTMENTS	0.00
COVERED CHARGES	83,488.57	CONTRACTUAL ALLOW	64,056.53
NON-COVERD CHARGES	209.15	TOTAL MEDICAID LIAB	19,432.04
		LESS: COB	19,432.04
		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	5		0	5,175.00		209.15
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	5,175.00		209.15
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	5,175.00		209.15

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,842.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	95.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,710.36	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,637.74	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,646.49	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	400.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,019.09	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,975.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,464.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,406.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,115.05	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,313.57	0.00
			TOTAL ACCOMODATIONS	5,175.00	209.15
			TOTAL CHARGES	83,488.57	209.15

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: 08/29/2018
Run Time: 00:45:27
Page: 5

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,266,726.05	ADJUSTMENTS	185,834.18
COVERED CHARGES	4,917,296.49	CONTRACTUAL ALLOW	4,479,215.06
NON-COVERD CHARGES	349,429.56	TOTAL MEDICAID LIAB	438,081.43
		LESS: COB	1,545.77
		LESS: COPAYMENT	1,290.00
		REIMBURSEMENT	435,245.66
		ALL OTHER	379,410.10
		FEE SCHEDULE-LAB	50,265.63
		INJECTABLE DRUGS	5,569.93

TOTAL NUMBER OF CLAIMS 1,382

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	188,272.09	5,114.99	OTHER LAB	126,686.21	0.00
MED/SURG SUPPLY	22,742.21	566.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	65.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	166,417.19	5,127.24	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	420,384.54	55,987.42	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,191.94	6,022.35	FEE SCHEDULE LAB	1,423,060.53	49,897.03
EKG/ECG	53,370.03	2,020.81	MRI SERVICES	107,155.40	12,337.45
IV THERAPY	829.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	470,432.98	54,303.23	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,183.66	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,428.07	5,316.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	154,755.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	167,982.03	23,021.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	920,532.89	18,161.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	105,115.57	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	271,844.56	90,408.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	361.50	361.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,343.94	753.74	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,692.05	1,369.39	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,922.49	5,885.13
LITHOTRIPSY	46,944.14	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	49,423.35	1,577.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,582.32	1,653.52			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,933.91	4,316.91			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,487.35	4,660.44			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,536.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,684.16	501.17			
			TOTAL ANCILLARY	4,917,296.49	349,429.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,917,296.49	349,429.56

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: 08/29/2018
Run Time: 00:45:32
Page: 7

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,643.57	ADJUSTMENTS	0.00
COVERED CHARGES	43,569.47	CONTRACTUAL ALLOW	31,495.72
NON-COVERD CHARGES	46,074.10	TOTAL MEDICAID LIAB	12,073.75
		LESS: COB	12,058.75
		LESS: COPAYMENT	15.00
		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

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,223.38	1,828.16	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,788.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,230.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,118.96	5,929.19	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,440.10	531.13
EKG/ECG	400.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	34,041.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,113.17	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,474.89	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,175.53	111.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,590.66	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,712.25	2,132.45
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	626.94	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	873.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,093.81	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,207.18	0.00			
			TOTAL ANCILLARY	43,569.47	46,074.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,569.47	46,074.10

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	178,992.99	ADJUSTMENTS	323.64
COVERED CHARGES	171,121.45	CONTRACTUAL ALLOW	168,604.15
NON-COVERD CHARGES	7,871.54	TOTAL MEDICAID LIAB	2,517.30
		LESS: COB	0.00
		LESS: COPAYMENT	85.81
		REIMBURSEMENT	2,431.49
		TOTAL NUMBER OF CLAIMS	45

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,069.16	15.06	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,696.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,865.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,214.09	4,611.61	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,305.70	0.00	FEE SCHEDULE LAB	21,085.68	283.52
EKG/ECG	420.17	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,806.97	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,214.21	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,631.19	129.14	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,562.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,202.48	2,832.21
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	3,268.69	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,778.16	0.00			
			TOTAL ANCILLARY	171,121.45	7,871.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	171,121.45	7,871.54

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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	01/01/17	THROUGH	12/31/17
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

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	552,243.40	ADJUSTMENTS	43,714.08
COVERED CHARGES	531,559.14	CONTRACTUAL ALLOW	487,821.06
NON-COVERD CHARGES	20,684.26	TOTAL MEDICAID LIAB	43,738.08
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	43,714.08

TOTAL NUMBER OF CLAIMS 8

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,920.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,916.20	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	7,292.98	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,233.98	228.30
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	354,689.07	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,813.28	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,410.87	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,939.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,887.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,673.09	9,496.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,770.98	10,959.52
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,011.31	0.00			
			TOTAL ANCILLARY	531,559.14	20,684.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	531,559.14	20,684.26

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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

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	01/01/17	THROUGH	12/31/17
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	07/01/16	THROUGH	06/30/17
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

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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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	07/01/16	THROUGH	06/30/17
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

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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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THE MEDICAL CENTER, INC.
5707 PEACHTREE PKWY
NORCROSS,GA 30092-2804

PROVIDER NUMBER
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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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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	07/01/16	THROUGH	06/30/17
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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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

PREMIER HEALTHCARE INVESTMENTS
 509 SUMTER STREET
 MONTEZUMA,GA 31063-2502

PROVIDER NUMBER 000149487A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,654,004.96	ADJUSTMENTS	112,289.39
COVERED CHARGES	7,413,122.20	CONTRACTUAL ALLOW	2,640,569.35
NON-COVERD CHARGES	240,882.76	TOTAL MEDICAID LIAB	4,772,552.85
		LESS: COB	2,640.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,769,912.18

TOTAL NUMBER OF ADMISSIONS 1,170

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,015		0	3,510,500.00		240,700.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,015		0	3,510,500.00		240,700.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5,015		0	3,510,500.00		240,700.00

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,024,387.65	0.00	OTHER LAB	1,873.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	623,185.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,515.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,192.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,334.77	0.00	MRI SERVICES	5,362.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	182.76
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	2,199,080.78	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	692.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,902,622.20	182.76
			TOTAL ACCOMODATIONS	3,510,500.00	240,700.00
			TOTAL CHARGES	7,413,122.20	240,882.76

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 01/01/17 THROUGH 12/31/17
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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,359.77	ADJUSTMENTS	135.96
COVERED CHARGES	72,752.77	CONTRACTUAL ALLOW	48,457.08
NON-COVERD CHARGES	607.00	TOTAL MEDICAID LIAB	24,295.69
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	24,022.69
		ALL OTHER	24,022.69
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	119

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	26,983.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,806.00	269.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	338.00
EKG/ECG	935.77	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,028.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,752.77	607.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,752.77	607.00

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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/31/17
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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PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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	01/01/17	THROUGH	12/31/17
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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
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

PREMIER HEALTHCARE INVESTMENTS
509 SUMTER STREET
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.
 1133 EAGLES LANDING PKWY
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER 000182388A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,629,667.93	ADJUSTMENTS	1,278,058.87
COVERED CHARGES	40,554,243.85	CONTRACTUAL ALLOW	31,491,347.69
NON-COVERD CHARGES	1,075,424.08	TOTAL MEDICAID LIAB	9,062,896.16
		LESS: COB	83,548.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,979,348.03

TOTAL NUMBER OF ADMISSIONS 923

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,708		0	3,433,920.00		572,152.00
ROUTINE NURSERY	689		0	1,446,083.00		55,277.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,397		0	4,880,003.00		627,429.00
SPECIAL CARE SERVICES						
CCU	614		0	1,831,202.00		0.00
ICU	406		0	1,209,437.00		0.00
NICU	199		0	716,358.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,219		0	3,756,997.00		0.00
TOTAL ACCOMODATIONS	5,616		0	8,637,000.00		627,429.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,340,257.88	58,750.54	OTHER LAB	360,351.00	622.00
MED/SURG SUPPLY	841,886.07	16,136.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,514,194.00	74,696.00	EDUCATION & TRAINING	6,540.00	0.00
RADIOLOGY-DIAGNOSTIC	759,841.00	4,365.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,779,229.00	7,181.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	250,492.02	10,268.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	227,518.00	666.00	MRI SERVICES	542,477.00	3,190.00
IV THERAPY	9,145.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,688,946.50	16,194.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	645,468.00	1,724.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,458,815.00	32,873.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	310,286.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	337,971.00	2,246.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,267,086.00	1,266.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	403,620.00	2,769.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	217,298.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	42,857.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	160,785.38	24,211.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	106,984.25	4,253.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	502,671.00	28,691.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,197.00	11,563.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	714,216.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	290,356.00	2,085.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	432,112.00	91,767.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	259,871.00	51,070.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,289,212.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,279.00	1,408.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,281.40	0.00			
			TOTAL ANCILLARY	31,917,243.85	447,995.08
			TOTAL ACCOMODATIONS	8,637,000.00	627,429.00
			TOTAL CHARGES	40,554,243.85	1,075,424.08

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	174,965.59	ADJUSTMENTS	0.00
COVERED CHARGES	168,062.59	CONTRACTUAL ALLOW	112,537.69
NON-COVERD CHARGES	6,903.00	TOTAL MEDICAID LIAB	55,524.90
		LESS: COB	55,524.90
		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	28		0	26,880.00		6,903.00
ROUTINE NURSERY	6		0	2,412.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	34		0	29,292.00		6,903.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	29,292.00		6,903.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,959.01	0.00	OTHER LAB	1,245.00	0.00
MED/SURG SUPPLY	10,538.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,069.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,106.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,849.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	238.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,905.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,840.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,706.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,397.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,927.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,128.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,740.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,389.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	416.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	324.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,481.62	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,438.00	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	3,074.00	0.00			
			TOTAL ANCILLARY	138,770.59	0.00
			TOTAL ACCOMODATIONS	29,292.00	6,903.00
			TOTAL CHARGES	168,062.59	6,903.00

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,154,342.19	ADJUSTMENTS	318,765.59
COVERED CHARGES	18,613,741.42	CONTRACTUAL ALLOW	16,244,851.26
NON-COVERD CHARGES	4,540,600.77	TOTAL MEDICAID LIAB	2,368,890.16
		LESS: COB	48,360.10
		LESS: COPAYMENT	3,989.23
		REIMBURSEMENT	2,316,540.83
		ALL OTHER	2,086,108.95
		FEE SCHEDULE-LAB	184,253.84
		INJECTABLE DRUGS	46,178.04

TOTAL NUMBER OF CLAIMS 5,493

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338,803.70	1,384.07
MED/SURG SUPPLY	320,788.50	54,277.56
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	932,859.00	85,010.00
CT SCAN	1,350,821.00	686,740.00
PHYSICAL THERAPY	64,250.00	6,455.08
EKG/ECG	263,819.00	9,990.00
IV THERAPY	44,630.00	81,144.00
OPERATING ROOM	1,531,451.00	275,668.00
LABOR/DELIVERY ROOM	137,784.00	0.00
RESPIRATORY SERVICES	68,766.00	17,885.00
ANESTHESIA	242,953.00	3,564.00
GI SERVICES	177,713.00	87,077.00
EMERGENCY ROOM	6,667,620.00	126,715.00
RECOVERY ROOM	357,451.00	5,381.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	195,947.00	521,946.00
OCCUPATIONAL THERAPY	15,037.00	7,845.03
SPEECH PATHOLOGY	4,843.00	10,614.00
RENAL DIALYSIS	0.00	55,175.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	96,431.00	8,233.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	574,432.00	258,929.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	60,242.00	37,827.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	195,922.00	206,706.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	389,557.00	407,177.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	110,438.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	299,756.36	8,521.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	323,116.00	90,059.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	336.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,179,781.00	120,800.00
MRI SERVICES	158,332.00	61,233.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	450,037.29	1,078,976.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	60,160.57	224,933.01
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	18,613,741.42	4,540,600.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,613,741.42	4,540,600.77

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	544,223.53	ADJUSTMENTS	0.00
COVERED CHARGES	435,783.23	CONTRACTUAL ALLOW	316,658.76
NON-COVERD CHARGES	108,440.30	TOTAL MEDICAID LIAB	119,124.47
		LESS: COB	119,061.49
		LESS: COPAYMENT	62.98
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,422.82	0.00	OTHER LAB	7,882.00	0.00
MED/SURG SUPPLY	6,798.76	561.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,780.00	512.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,038.00	22,119.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,781.00	3,516.00
EKG/ECG	2,997.00	0.00	MRI SERVICES	4,238.00	0.00
IV THERAPY	933.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,244.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,260.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,099.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,556.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	132,755.00	1,722.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,821.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,655.86	13,805.06
RADIOLOGY THERAPEUTIC	7,107.00	16,212.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	23,987.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,517.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,628.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,024.99	1,771.64
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,599.00	10,560.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,312.00	649.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	12,876.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,333.80	149.00			
			TOTAL ANCILLARY	435,783.23	108,440.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	435,783.23	108,440.30

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	771,885.63	ADJUSTMENTS	164.82
COVERED CHARGES	671,024.00	CONTRACTUAL ALLOW	646,110.54
NON-COVERD CHARGES	100,861.63	TOTAL MEDICAID LIAB	24,913.46
		LESS: COB	1,978.06
		LESS: COPAYMENT	656.55
		REIMBURSEMENT	22,278.85
		TOTAL NUMBER OF CLAIMS	410

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,419.17	0.00	OTHER LAB	3,282.00	6,564.00
MED/SURG SUPPLY	3,679.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,386.00	4,575.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,343.00	42,059.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	151,691.00	3,874.00
EKG/ECG	7,992.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	25,095.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	656.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,426.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	417,672.00	1,769.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,243.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,501.19	2,158.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,254.00	14,767.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,478.85	0.00			
			TOTAL ANCILLARY	671,024.00	100,861.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	671,024.00	100,861.63

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,368.07	ADJUSTMENTS	0.00
COVERED CHARGES	17,230.04	CONTRACTUAL ALLOW	11,418.60
NON-COVERD CHARGES	1,138.03	TOTAL MEDICAID LIAB	5,811.44
		LESS: COB	5,793.44
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58.19	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	572.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,725.00	1,076.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,720.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	154.85	62.03
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,230.04	1,138.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,230.04	1,138.03

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HENRY HOSPITAL, INC.
1133 EAGLES LANDING PKWY
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	983,920.93	ADJUSTMENTS	43,858.80
COVERED CHARGES	803,259.66	CONTRACTUAL ALLOW	720,956.91
NON-COVERD CHARGES	180,661.27	TOTAL MEDICAID LIAB	82,302.75
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	82,245.75
		TOTAL NUMBER OF CLAIMS	15

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,242.67	0.00	OTHER LAB	1,641.00	0.00
MED/SURG SUPPLY	47,735.07	5,134.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,282.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,391.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,935.00	252.00
EKG/ECG	666.00	333.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	228,106.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	428.00	248.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,322.00	3,778.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,734.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	312,115.35	14,497.09
RADIOLOGY THERAPEUTIC	6,994.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	49.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,106.56	146,682.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,773.00	999.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	88,478.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,399.01	298.00			
			TOTAL ANCILLARY	803,259.66	180,661.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	803,259.66	180,661.27

Report : 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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,958,618.66	ADJUSTMENTS	2,022,147.10
COVERED CHARGES	56,256,067.47	CONTRACTUAL ALLOW	46,527,461.59
NON-COVERD CHARGES	10,702,551.19	TOTAL MEDICAID LIAB	9,728,605.88
		LESS: COB	132,095.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,596,510.57

TOTAL NUMBER OF ADMISSIONS 1,213

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,376		6	10,611,786.39		10,350,768.06
ROUTINE NURSERY	244		0	375,256.04		63,313.20
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,620		6	10,987,042.43		10,414,081.26
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	975		0	2,912,697.20		0.00
NICU	22		0	85,134.50		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	997		0	2,997,831.70		0.00
TOTAL ACCOMODATIONS	8,617		6	13,984,874.13		10,414,081.26

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,667,024.24	1,046.15	OTHER LAB	278,974.95	0.00
MED/SURG SUPPLY	2,273,924.45	5,206.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,461,816.82	2,925.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	830,832.06	0.00	OTHER THERAPEUTIC SVC	0.00	1,546.68
CT SCAN	2,523,724.74	16,808.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	496,418.53	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	628,865.02	0.00	MRI SERVICES	413,446.43	0.00
IV THERAPY	5,658.64	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,486,862.82	11,501.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	394,062.49	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,994,192.53	14,040.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	609,200.16	0.00	AMBULANCE	0.00	0.00
GI SERVICES	458,386.57	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,335,978.93	2,934.32	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	503,782.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	30,671.46
LABORATORY PATHOLOGIC	255,476.42	0.00	INJECTABLE DRUGS	6,756,728.13	269.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	316,723.95	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	316,912.99	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	316,623.02	38,498.29	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,740.57	252.09	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	191,748.70	0.00	IMPL DEV CHARGE PATIENTS	977,053.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	293,395.79	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	115,535.14	158,357.99			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	566,525.25	1,169.16			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	566,939.07	3,241.68			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	95,594.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	120,044.63	0.00			
			TOTAL ANCILLARY	42,271,193.34	288,469.93
			TOTAL ACCOMODATIONS	13,984,874.13	10,414,081.26
			TOTAL CHARGES	56,256,067.47	10,702,551.19

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: 08/29/2018
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EASTSIDE MEDICAL CENTER LLC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1700 MEDICAL WAY	000190088A	SERVICE DATES	09/01/16	THROUGH	08/31/17
SNELLVILLE,GA 30078-2195		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
24	2017286063841	08/04/17 - 08/23/17	10/23/17	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	562,111.26	ADJUSTMENTS	0.00
COVERED CHARGES	550,021.74	CONTRACTUAL ALLOW	336,223.97
NON-COVERD CHARGES	12,089.52	TOTAL MEDICAID LIAB	213,797.77
		LESS: COB	213,797.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14		0	19,830.60		1,023.12
ROUTINE NURSERY	57		0	118,027.08		11,066.40
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	71		0	137,857.68		12,089.52
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,479.68		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,479.68		0.00
TOTAL ACCOMODATIONS	72		0	140,337.36		12,089.52

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,897.82	0.00	OTHER LAB	1,583.30	0.00
MED/SURG SUPPLY	42,777.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	123,601.15	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,450.02	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,031.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,972.15	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,179.79	0.00	MRI SERVICES	5,003.75	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,179.97	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,961.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,681.92	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,502.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,734.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,730.94	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,233.45	0.00	INJECTABLE DRUGS	52,118.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,897.25	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	355.88	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,434.46	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,204.07	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,152.22	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	409,684.38	0.00
			TOTAL ACCOMODATIONS	140,337.36	12,089.52
			TOTAL CHARGES	550,021.74	12,089.52

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,217,511.12	ADJUSTMENTS	75,618.43
COVERED CHARGES	15,830,647.86	CONTRACTUAL ALLOW	14,518,426.29
NON-COVERD CHARGES	1,386,863.26	TOTAL MEDICAID LIAB	1,312,221.57
		LESS: COB	888.57
		LESS: COPAYMENT	2,929.16
		REIMBURSEMENT	1,308,403.84
		ALL OTHER	1,201,733.94
		FEE SCHEDULE-LAB	93,493.94
		INJECTABLE DRUGS	13,175.96

TOTAL NUMBER OF CLAIMS 3,271

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	376,225.28	55,281.48	OTHER LAB	162,077.07	0.00
MED/SURG SUPPLY	324,318.75	8,769.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	620,669.00	94,674.76	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,964,695.05	184,285.23	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,186.13	11,639.78	FEE SCHEDULE LAB	3,502,974.12	122,004.07
EKG/ECG	355,624.22	0.00	MRI SERVICES	155,252.19	58,069.10
IV THERAPY	757,457.70	9,218.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	441,411.46	103,869.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,144.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,565.94	7,929.86	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	244,301.47	0.00	AMBULANCE	0.00	0.00
GI SERVICES	76,791.06	49,590.63	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,281,122.02	26,710.62	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	440,789.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,840.83
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	189,880.75	41,379.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,153.60	10,298.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,941.30	7,718.16	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,564.98	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	108,084.28	18,992.49	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	191,078.70	0.00	IMPL DEV CHARGE PATIENTS	89,682.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	338,750.48	131,295.78			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,532.20	10,079.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	392,024.27	65,460.68			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	195,992.59	121,276.26			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,985.46	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	474,936.71	241,913.91			
			TOTAL ANCILLARY	15,830,647.86	1,386,863.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,830,647.86	1,386,863.26

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	299,518.00	ADJUSTMENTS	0.00
COVERED CHARGES	228,159.67	CONTRACTUAL ALLOW	169,592.74
NON-COVERD CHARGES	71,358.33	TOTAL MEDICAID LIAB	58,566.93
		LESS: COB	58,505.71
		LESS: COPAYMENT	61.22
		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

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,608.24	1,703.06	OTHER LAB	10,565.33	0.00
MED/SURG SUPPLY	7,724.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,001.15	2,276.13	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,237.62	10,986.59	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,801.08	19,354.77
EKG/ECG	3,699.85	739.97	MRI SERVICES	4,987.94	0.00
IV THERAPY	4,332.98	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	10,504.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,673.68	705.88	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,973.92	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	83,567.08	1,606.77	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,542.83	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	737.75	994.83
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	1,560.70	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,541.76	589.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,489.25	11,495.44			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,081.48			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,076.11			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,674.96	5,682.26			
			TOTAL ANCILLARY	228,159.67	71,358.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	228,159.67	71,358.33

Report : CLM-0808-0
Process : CLMJ0800
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: 08/29/2018
Run Time: 00:46:36
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,435,214.02	ADJUSTMENTS	214.76
COVERED CHARGES	1,398,193.12	CONTRACTUAL ALLOW	1,376,656.22
NON-COVERD CHARGES	37,020.90	TOTAL MEDICAID LIAB	21,536.90
		LESS: COB	0.00
		LESS: COPAYMENT	693.00
		REIMBURSEMENT	20,843.90
		TOTAL NUMBER OF CLAIMS	385

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,195.65	3,259.17	OTHER LAB	3,166.60	0.00
MED/SURG SUPPLY	1,538.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,030.24	6,294.38	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	180,096.54	7,091.06	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	336,337.16	9,146.87
EKG/ECG	16,169.72	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	83,701.51	187.59	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,485.40	299.28	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	662,688.35	3,186.99	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,582.90	3,518.99
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	287.69	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,201.05	3,748.88			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,398,193.12	37,020.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,398,193.12	37,020.90

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,274.70	ADJUSTMENTS	0.00
COVERED CHARGES	14,568.44	CONTRACTUAL ALLOW	9,044.41
NON-COVERD CHARGES	3,706.26	TOTAL MEDICAID LIAB	5,524.03
		LESS: COB	5,524.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	356.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	46.75	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	5,295.22	107.36
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,765.52	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	61.96	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	0.00	3,598.90			
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	1,042.92	0.00			
			TOTAL ANCILLARY	14,568.44	3,706.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,568.44	3,706.26

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,034,925.45	ADJUSTMENTS	5,562.47
COVERED CHARGES	984,172.82	CONTRACTUAL ALLOW	934,110.59
NON-COVERD CHARGES	50,752.63	TOTAL MEDICAID LIAB	50,062.23
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	50,029.23

TOTAL NUMBER OF CLAIMS 9

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,487.19	4,683.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65,039.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,566.31	577.79	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	859.04	FEE SCHEDULE LAB	19,456.53	175.53
EKG/ECG	5,179.79	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	115,916.30	35,153.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,231.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,784.86	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,729.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,736.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,090.69	6,554.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	672.55	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	541,863.50	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	162,836.25	2,076.11			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,255.44	0.00			
			TOTAL ANCILLARY	984,172.82	50,752.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	984,172.82	50,752.63

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

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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	09/01/16	THROUGH	08/31/17
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: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC
 102 HOSPITAL CIR
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	946,721.75	ADJUSTMENTS	17,917.54
COVERED CHARGES	920,342.75	CONTRACTUAL ALLOW	599,738.95
NON-COVERD CHARGES	26,379.00	TOTAL MEDICAID LIAB	320,603.80
		LESS: COB	3,609.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	316,994.69

TOTAL NUMBER OF ADMISSIONS 74

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	188		0	133,680.00		26,049.00
ROUTINE NURSERY	41		0	27,880.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	229		0	161,560.00		26,049.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	229		0	161,560.00		26,049.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	278,173.65	0.00	OTHER LAB	833.00	0.00
MED/SURG SUPPLY	159,570.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	92,172.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,709.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,992.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,719.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,610.00	0.00	MRI SERVICES	1,879.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	91,660.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,248.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,842.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,520.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,709.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,314.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,736.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	163.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	604.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,420.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,672.00	330.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	4,237.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	758,782.75	330.00
			TOTAL ACCOMODATIONS	161,560.00	26,049.00
			TOTAL CHARGES	920,342.75	26,379.00

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,374,201.15	ADJUSTMENTS	494.91
COVERED CHARGES	1,173,783.15	CONTRACTUAL ALLOW	924,047.77
NON-COVERD CHARGES	200,418.00	TOTAL MEDICAID LIAB	249,735.38
		LESS: COB	745.40
		LESS: COPAYMENT	762.00
		REIMBURSEMENT	248,227.98
		ALL OTHER	208,096.56
		FEE SCHEDULE-LAB	39,908.78
		INJECTABLE DRUGS	222.64
		TOTAL NUMBER OF CLAIMS	1,036

DONALSONVILLE HOSPITAL INC
 102 HOSPITAL CIR
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154,772.50	127.00	OTHER LAB	10,437.00	0.00
MED/SURG SUPPLY	99,750.00	1,166.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	708.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,774.00	4,088.00	OTHER THERAPEUTIC SVC	0.00	20,346.00
CT SCAN	62,763.00	16,772.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,811.00	45,507.00	FEE SCHEDULE LAB	398,014.65	19,906.00
EKG/ECG	8,750.00	0.00	MRI SERVICES	15,556.00	0.00
IV THERAPY	1,243.00	32,724.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	62,521.00	32,457.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	215.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,837.00	165.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	131,976.00	902.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,898.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,271.00	1,626.00
RADIOLOGY THERAPEUTIC	0.00	0.00	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	0.00	1,120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	60,916.00	4,839.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,552.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	984.00	4,920.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,742.00	12,633.00			
			TOTAL ANCILLARY	1,173,783.15	200,418.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,173,783.15	200,418.00

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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,103.00	ADJUSTMENTS	0.00
COVERED CHARGES	18,061.00	CONTRACTUAL ALLOW	4,399.41
NON-COVERD CHARGES	4,042.00	TOTAL MEDICAID LIAB	13,661.59
		LESS: COB	13,652.59
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,270.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,303.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	113.00
CT SCAN	1,160.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,383.00	234.00
EKG/ECG	70.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,233.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,512.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	608.00	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	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,682.00	462.00			
			TOTAL ANCILLARY	18,061.00	4,042.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,061.00	4,042.00

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,686.50	ADJUSTMENTS	0.00
COVERED CHARGES	99,174.50	CONTRACTUAL ALLOW	93,916.14
NON-COVERD CHARGES	6,512.00	TOTAL MEDICAID LIAB	5,258.36
		LESS: COB	0.00
		LESS: COPAYMENT	144.00
		REIMBURSEMENT	5,114.36
		TOTAL NUMBER OF CLAIMS	94

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,885.50	0.00	OTHER LAB	2,196.00	0.00
MED/SURG SUPPLY	378.00	86.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,404.00	222.00	OTHER THERAPEUTIC SVC	0.00	3,639.00
CT SCAN	20,389.00	661.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,291.00	1,113.00
EKG/ECG	420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	113.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	123.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,218.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,342.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	339.00	678.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189.00	0.00			
			TOTAL ANCILLARY	99,174.50	6,512.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	99,174.50	6,512.00

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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

DONALSONVILLE HOSPITAL INC
102 HOSPITAL CIR
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,561.00	ADJUSTMENTS	0.00
COVERED CHARGES	47,561.00	CONTRACTUAL ALLOW	36,470.54
NON-COVERD CHARGES	0.00	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

DONALSONVILLE HOSPITAL INC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
102 HOSPITAL CIR	000206181A	SERVICE DATES	07/01/16	THROUGH	06/30/17
DONALSONVILLE,GA 39845-1100		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,439.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,168.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	0.00	0.00	FEE SCHEDULE LAB	216.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,094.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	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	2,146.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	47,561.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,561.00	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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,807,318.52	ADJUSTMENTS	1,180,396.80
COVERED CHARGES	10,777,462.32	CONTRACTUAL ALLOW	7,377,258.88
NON-COVERD CHARGES	1,029,856.20	TOTAL MEDICAID LIAB	3,400,203.44
		LESS: COB	62,143.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,338,059.59

TOTAL NUMBER OF ADMISSIONS 52

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,558		0	2,297,955.00		18,848.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,558		0	2,297,955.00		18,848.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	61		0	181,040.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		576	0.00		853,632.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	61		576	181,040.00		853,632.00
TOTAL ACCOMODATIONS	1,619		576	2,478,995.00		872,480.00

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	860,680.15	2,455.20	OTHER LAB	102,005.00	0.00
MED/SURG SUPPLY	1,769,884.00	41,328.00	RECREATIONAL THERAPY	1,264.00	0.00
LABORATORY-GENERAL	304,373.00	10,624.00	EDUCATION & TRAINING	1,757.00	0.00
RADIOLOGY-DIAGNOSTIC	131,410.50	0.00	OTHER THERAPEUTIC SVC	8,412.00	2,306.00
CT SCAN	124,201.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	684,490.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,124.00	0.00	MRI SERVICES	16,124.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,079,158.11	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,151,128.00	61,079.00	FREE STANDING CLINIC	0.00	0.00
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	21,838.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,125,725.20	765.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	638,708.00	327.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	172,894.03	7,020.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	39.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	863.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,976.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	638.00
OTHER IMAGING SERVICE	1,552.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,230.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,266.53	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,273.80	0.00			
AMBULATORY SURGERY	55,866.00	8,094.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,444.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,521.00	0.00			
			TOTAL ANCILLARY	8,298,467.32	157,376.20
			TOTAL ACCOMODATIONS	2,478,995.00	872,480.00
			TOTAL CHARGES	10,777,462.32	1,029,856.20

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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SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017047000285	07/07/16 - 08/10/16	02/20/17	0.00	638.00	0.00	62,143.85	0.00
TOTAL				0.00	638.00	0.00	62,143.85	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: 08/29/2018
 Run Time: 00:55:08
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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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,533,588.76	ADJUSTMENTS	0.00
COVERED CHARGES	1,521,674.76	CONTRACTUAL ALLOW	720,437.64
NON-COVERD CHARGES	11,914.00	TOTAL MEDICAID LIAB	801,237.12
		LESS: COB	801,237.12
		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	295		0	437,190.00		3,363.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	295		0	437,190.00		3,363.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	15,174.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	15,174.00		0.00
TOTAL ACCOMODATIONS	300		0	452,364.00		3,363.00

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	175,220.30	0.00	OTHER LAB	4,822.00	0.00
MED/SURG SUPPLY	230,964.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,697.00	0.00	EDUCATION & TRAINING	8,243.00	0.00
RADIOLOGY-DIAGNOSTIC	4,028.00	0.00	OTHER THERAPEUTIC SVC	2,099.00	1,236.00
CT SCAN	7,744.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	120,204.00	670.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	948.00	0.00	MRI SERVICES	3,315.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,796.66	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134,397.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	78,701.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	136,447.00	662.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	77,916.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	78.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,905.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,685.80	0.00			
AMBULATORY SURGERY	6,092.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,991.00	0.00			
			TOTAL ANCILLARY	1,069,310.76	8,551.00
			TOTAL ACCOMODATIONS	452,364.00	3,363.00
			TOTAL CHARGES	1,521,674.76	11,914.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2217237016311	02/13/17 - 04/29/17	08/28/17	0.00	5,905.00	0.00	147,242.08	0.00
TOTAL				0.00	5,905.00	0.00	147,242.08	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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,287,761.66	ADJUSTMENTS	133,189.74
COVERED CHARGES	5,177,915.40	CONTRACTUAL ALLOW	3,341,545.88
NON-COVERD CHARGES	1,109,846.26	TOTAL MEDICAID LIAB	1,836,369.52
		LESS: COB	76,132.78
		LESS: COPAYMENT	4,608.00
		REIMBURSEMENT	1,755,628.74
		ALL OTHER	551,377.89
		FEE SCHEDULE-LAB	28,341.84
		INJECTABLE DRUGS	1,175,909.01

TOTAL NUMBER OF CLAIMS 1,522

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,038.10	44,110.45	OTHER LAB	23,587.00	4,944.00
MED/SURG SUPPLY	54,445.00	66.00	RECREATIONAL THERAPY	0.00	4,582.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	4,403.00
RADIOLOGY-DIAGNOSTIC	24,978.00	1,785.00	OTHER THERAPEUTIC SVC	0.00	4,676.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	143,123.00	248,416.18	FEE SCHEDULE LAB	221,905.00	1,494.00
EKG/ECG	316.00	0.00	MRI SERVICES	383,715.00	48,830.00
IV THERAPY	9,842.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,756.00	302.00	FREE STANDING CLINIC	0.00	0.00
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	3,600,187.30	391,839.45
RADIOLOGY THERAPEUTIC	131,727.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	61,547.00	221,893.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,685.00	80,836.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	920.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	261,309.00	446.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	24,188.00
OTHER IMAGING SERVICE	22,328.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	4,020.00	1,340.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	195,407.00	24,775.00			
			TOTAL ANCILLARY	5,177,915.40	1,109,846.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,177,915.40	1,109,846.26

SHEPHERD CENTER
 2020 PEACHTREE RD NW
 ATLANTA,GA 30309-1426

PROVIDER NUMBER
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016287079713	08/23/16 - 08/23/16	10/17/16	0.00	195.00	0.00	0.00	0.00
952	2016287079713	08/08/16 - 08/08/16	10/17/16	0.00	195.00	0.00	0.00	0.00
952	2016287079713	08/26/16 - 08/26/16	10/17/16	0.00	168.00	0.00	0.00	0.00
952	2016287079713	08/25/16 - 08/25/16	10/17/16	0.00	168.00	0.00	0.00	0.00
952	2016287079713	08/23/16 - 08/23/16	10/17/16	0.00	168.00	0.00	0.00	0.00
952	2016287079713	08/22/16 - 08/22/16	10/17/16	0.00	168.00	0.00	0.00	0.00
952	2016287079713	08/17/16 - 08/17/16	10/17/16	0.00	126.00	0.00	0.00	0.00
952	2016287079713	08/12/16 - 08/12/16	10/17/16	0.00	168.00	0.00	0.00	0.00
952	2016287079713	08/09/16 - 08/09/16	10/17/16	0.00	168.00	0.00	0.00	0.00
952	2016293072503	08/25/16 - 08/25/16	10/24/16	0.00	260.00	0.00	0.00	0.00
952	2016293072503	08/22/16 - 08/22/16	10/24/16	0.00	260.00	0.00	0.00	0.00
952	2016293072503	09/06/16 - 09/06/16	10/24/16	0.00	260.00	0.00	0.00	0.00
952	2016293072503	09/02/16 - 09/02/16	10/24/16	0.00	260.00	0.00	0.00	0.00
952	2016293072503	08/24/16 - 08/24/16	10/24/16	0.00	130.00	0.00	0.00	0.00
952	2016293072503	09/16/16 - 09/16/16	10/24/16	0.00	168.00	0.00	0.00	0.00
952	2016293072503	09/14/16 - 09/14/16	10/24/16	0.00	168.00	0.00	0.00	0.00
952	2016293072503	09/13/16 - 09/13/16	10/24/16	0.00	126.00	0.00	0.00	0.00
952	2016293072503	09/01/16 - 09/01/16	10/24/16	0.00	168.00	0.00	0.00	0.00
952	2016293072503	08/24/16 - 08/24/16	10/24/16	0.00	168.00	0.00	0.00	0.00
952	2017017054684	12/19/16 - 12/19/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	12/15/16 - 12/15/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	12/13/16 - 12/13/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	12/08/16 - 12/08/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	12/05/16 - 12/05/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	11/30/16 - 11/30/16	01/23/17	0.00	84.00	0.00	0.00	0.00
952	2017017054684	11/25/16 - 11/25/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	11/18/16 - 11/18/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	12/16/16 - 12/16/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017017054684	11/23/16 - 11/23/16	01/23/17	0.00	168.00	0.00	0.00	0.00
952	2017047007228	12/29/16 - 12/29/16	02/20/17	0.00	65.00	0.00	0.00	0.00
952	2017047007228	01/06/17 - 01/06/17	02/20/17	0.00	168.00	0.00	0.00	0.00
952	2017047007228	01/04/17 - 01/04/17	02/20/17	0.00	84.00	0.00	0.00	0.00
952	2017047007228	12/29/16 - 12/29/16	02/20/17	0.00	126.00	0.00	0.00	0.00
952	2017067071488	10/31/16 - 10/31/16	03/13/17	0.00	520.00	0.00	1,986.14	0.00
952	2017067071488	09/30/16 - 09/30/16	03/13/17	0.00	260.00	0.00	1,986.14	0.00
952	2017067071488	11/30/16 - 11/30/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/23/16 - 11/23/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/21/16 - 11/21/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/18/16 - 11/18/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/11/16 - 11/11/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/04/16 - 11/04/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/03/16 - 11/03/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00

SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	DATE	DATE	PROV#	AMOUNT	DATE	AMOUNT	DATE	AMOUNT
952	2017067071488	11/02/16	- 11/02/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/01/16	- 11/01/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/31/16	- 10/31/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/27/16	- 10/27/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/26/16	- 10/26/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/25/16	- 10/25/16	03/13/17	0.00	336.00	0.00	1,986.14	0.00
952	2017067071488	10/24/16	- 10/24/16	03/13/17	0.00	336.00	0.00	1,986.14	0.00
952	2017067071488	10/21/16	- 10/21/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/20/16	- 10/20/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/19/16	- 10/19/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/18/16	- 10/18/16	03/13/17	0.00	336.00	0.00	1,986.14	0.00
952	2017067071488	10/17/16	- 10/17/16	03/13/17	0.00	336.00	0.00	1,986.14	0.00
952	2017067071488	10/14/16	- 10/14/16	03/13/17	0.00	210.00	0.00	1,986.14	0.00
952	2017067071488	10/13/16	- 10/13/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/12/16	- 10/12/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/10/16	- 10/10/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/07/16	- 10/07/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	10/06/16	- 10/06/16	03/13/17	0.00	210.00	0.00	1,986.14	0.00
952	2017067071488	10/03/16	- 10/03/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	09/30/16	- 09/30/16	03/13/17	0.00	294.00	0.00	1,986.14	0.00
952	2017067071488	09/28/16	- 09/28/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	09/27/16	- 09/27/16	03/13/17	0.00	168.00	0.00	1,986.14	0.00
952	2017067071488	11/15/16	- 11/15/16	03/13/17	0.00	260.00	0.00	1,986.14	0.00
952	5917068001652	01/26/17	- 01/26/17	03/13/17	0.00	260.00	0.00	0.00	0.00
952	5917068001652	01/12/17	- 01/12/17	03/13/17	0.00	260.00	0.00	0.00	0.00
952	5917068001652	01/20/17	- 01/20/17	03/13/17	0.00	168.00	0.00	0.00	0.00
952	5917068001652	01/10/17	- 01/10/17	03/13/17	0.00	168.00	0.00	0.00	0.00
952	5917068001652	12/30/16	- 12/30/16	03/13/17	0.00	168.00	0.00	0.00	0.00
952	5917068001652	12/23/16	- 12/23/16	03/13/17	0.00	168.00	0.00	0.00	0.00
952	5917068001652	12/19/16	- 12/19/16	03/13/17	0.00	168.00	0.00	0.00	0.00
952	2017073014511	12/28/16	- 12/28/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	2017073014511	12/20/16	- 12/20/16	03/20/17	0.00	130.00	0.00	0.00	0.00
952	2017073014511	12/08/16	- 12/08/16	03/20/17	0.00	130.00	0.00	0.00	0.00
952	2017073014511	12/01/16	- 12/01/16	03/20/17	0.00	65.00	0.00	0.00	0.00
952	2017073014511	11/21/16	- 11/21/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	2017073014511	12/16/16	- 12/16/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	2017073014511	12/20/16	- 12/20/16	03/20/17	0.00	65.00	0.00	0.00	0.00
952	2017073014511	12/08/16	- 12/08/16	03/20/17	0.00	65.00	0.00	0.00	0.00
952	2017073014511	12/01/16	- 12/01/16	03/20/17	0.00	130.00	0.00	0.00	0.00
952	2017090079792	02/24/17	- 02/24/17	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079792	02/15/17	- 02/15/17	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079792	02/08/17	- 02/08/17	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079792	02/17/17	- 02/17/17	04/10/17	0.00	126.00	0.00	0.00	0.00
952	2017090079907	04/12/16	- 04/12/16	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079907	05/04/16	- 05/04/16	04/10/17	0.00	336.00	0.00	0.00	0.00
952	2017090079907	04/29/16	- 04/29/16	04/10/17	0.00	126.00	0.00	0.00	0.00

SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	DATE	DATE	PROV#	AMOUNT	PAY#	AMOUNT	SERV#	AMOUNT
952	2017090079907	04/18/16	- 04/18/16	04/10/17	0.00	126.00	0.00	0.00	0.00
952	2017090079907	04/07/16	- 04/07/16	04/10/17	0.00	126.00	0.00	0.00	0.00
952	2017090079907	05/11/16	- 05/11/16	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079907	05/10/16	- 05/10/16	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079907	05/03/16	- 05/03/16	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079907	04/27/16	- 04/27/16	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017090079907	04/05/16	- 04/05/16	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017093054583	11/11/16	- 11/11/16	04/10/17	0.00	260.00	0.00	0.00	0.00
952	2017093054583	10/19/16	- 10/19/16	04/10/17	0.00	130.00	0.00	0.00	0.00
952	2017093054583	10/27/16	- 10/27/16	04/10/17	0.00	195.00	0.00	0.00	0.00
952	2017093054583	10/21/16	- 10/21/16	04/10/17	0.00	260.00	0.00	0.00	0.00
952	2017093054583	11/14/16	- 11/14/16	04/10/17	0.00	168.00	0.00	0.00	0.00
952	2017093054583	11/03/16	- 11/03/16	04/10/17	0.00	168.00	0.00	0.00	0.00
952	2017093054583	11/01/16	- 11/01/16	04/10/17	0.00	260.00	0.00	0.00	0.00
952	5917109000561	02/07/17	- 02/07/17	04/24/17	0.00	260.00	0.00	0.00	0.00
952	5917109000561	02/09/17	- 02/09/17	04/24/17	0.00	168.00	0.00	0.00	0.00
952	5917109000561	02/06/17	- 02/06/17	04/24/17	0.00	336.00	0.00	0.00	0.00
952	5917109000561	02/03/17	- 02/03/17	04/24/17	0.00	168.00	0.00	0.00	0.00
952	5917109000561	02/01/17	- 02/01/17	04/24/17	0.00	126.00	0.00	0.00	0.00
952	5917109000561	01/30/17	- 01/30/17	04/24/17	0.00	168.00	0.00	0.00	0.00
952	5917109000561	01/25/17	- 01/25/17	04/24/17	0.00	168.00	0.00	0.00	0.00
952	2017123079629	02/17/17	- 02/17/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	02/08/17	- 02/08/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	02/06/17	- 02/06/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	01/26/17	- 01/26/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	01/24/17	- 01/24/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	01/20/17	- 01/20/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	01/11/17	- 01/11/17	05/08/17	0.00	195.00	0.00	0.00	0.00
952	2017123079629	12/30/16	- 12/30/16	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	12/28/16	- 12/28/16	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	02/02/17	- 02/02/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	01/31/17	- 01/31/17	05/08/17	0.00	260.00	0.00	0.00	0.00
952	2017123079629	01/10/17	- 01/10/17	05/08/17	0.00	168.00	0.00	0.00	0.00
952	2217157009709	03/23/17	- 03/23/17	06/12/17	0.00	260.00	0.00	0.00	0.00
952	2217157009709	04/11/17	- 04/11/17	06/12/17	0.00	172.00	0.00	0.00	0.00
952	2217157009709	04/05/17	- 04/05/17	06/12/17	0.00	172.00	0.00	0.00	0.00
952	2217157009709	03/27/17	- 03/27/17	06/12/17	0.00	336.00	0.00	0.00	0.00

TOTAL 0.00 24,188.00 0.00 63,556.48 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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	440,935.95	ADJUSTMENTS	0.00
COVERED CHARGES	322,067.65	CONTRACTUAL ALLOW	110,144.92
NON-COVERD CHARGES	118,868.30	TOTAL MEDICAID LIAB	211,922.73
		LESS: COB	211,684.02
		LESS: COPAYMENT	238.71
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 95

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	4,017.10	OTHER LAB	1,178.00	1,494.00
MED/SURG SUPPLY	4,809.00	0.00	RECREATIONAL THERAPY	632.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	604.00
RADIOLOGY-DIAGNOSTIC	3,577.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,266.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	544.00	36,011.00	FEE SCHEDULE LAB	6,967.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,604.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	248,426.65	5,253.20
RADIOLOGY THERAPEUTIC	6,175.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,120.00	35,147.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	13,054.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	170.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,441.00	657.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,182.00
OTHER IMAGING SERVICE	751.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	670.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,843.00	16,343.00			
			TOTAL ANCILLARY	322,067.65	118,868.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	322,067.65	118,868.30

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017016030156	09/22/16 - 09/22/16	01/23/17	0.00	260.00	0.00	22,521.90	0.00
952	2017016030156	09/16/16 - 09/16/16	01/23/17	0.00	168.00	0.00	22,521.90	0.00
952	2017016030156	09/06/16 - 09/06/16	01/23/17	0.00	168.00	0.00	22,521.90	0.00
952	2017016030156	09/02/16 - 09/02/16	01/23/17	0.00	84.00	0.00	22,521.90	0.00
952	2017016030156	08/31/16 - 08/31/16	01/23/17	0.00	126.00	0.00	22,521.90	0.00
952	2017016030156	08/29/16 - 08/29/16	01/23/17	0.00	168.00	0.00	22,521.90	0.00
952	2017016030156	08/26/16 - 08/26/16	01/23/17	0.00	168.00	0.00	22,521.90	0.00
952	2017016030156	08/24/16 - 08/24/16	01/23/17	0.00	126.00	0.00	22,521.90	0.00
952	2017016030156	08/18/16 - 08/18/16	01/23/17	0.00	126.00	0.00	22,521.90	0.00
952	2017016030156	08/12/16 - 08/12/16	01/23/17	0.00	168.00	0.00	22,521.90	0.00
952	5917157001899	02/13/17 - 02/13/17	06/12/17	0.00	260.00	0.00	3,400.62	0.00
952	5917157001899	02/21/17 - 02/21/17	06/12/17	0.00	260.00	0.00	3,400.62	0.00
952	5917157001899	02/20/17 - 02/20/17	06/12/17	0.00	168.00	0.00	3,400.62	0.00
952	2017173007502	02/13/17 - 02/13/17	06/26/17	0.00	260.00	0.00	9,461.67	0.00
952	2017173007502	02/27/17 - 02/27/17	06/26/17	0.00	168.00	0.00	9,461.67	0.00
952	2017173007502	02/20/17 - 02/20/17	06/26/17	0.00	168.00	0.00	9,461.67	0.00
952	2017173007502	02/07/17 - 02/07/17	06/26/17	0.00	168.00	0.00	9,461.67	0.00
952	2017173007502	02/08/17 - 02/08/17	06/26/17	0.00	168.00	0.00	9,461.67	0.00
TOTAL				0.00	3,182.00	0.00	282,729.21	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: 08/29/2018
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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	04/01/16	THROUGH	03/31/17
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: 08/29/2018
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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	04/01/16	THROUGH	03/31/17
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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	136,868.00	ADJUSTMENTS	22,067.22
COVERED CHARGES	93,835.00	CONTRACTUAL ALLOW	60,405.67
NON-COVERD CHARGES	43,033.00	TOTAL MEDICAID LIAB	33,429.33
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	33,096.33

TOTAL NUMBER OF CLAIMS 3

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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 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	112.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,125.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,332.00	18,168.00	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	38,974.00	13,734.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,841.00	7,930.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	576.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,076.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	93,835.00	43,033.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,835.00	43,033.00

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

SHEPHERD CENTER
2020 PEACHTREE RD NW
ATLANTA,GA 30309-1426

PROVIDER NUMBER
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5917075001324	10/27/16 - 10/27/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	5917075001324	10/17/16 - 10/17/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	5917075001324	10/05/16 - 10/05/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	5917075001324	09/29/16 - 09/29/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	5917075001324	09/28/16 - 09/28/16	03/20/17	0.00	195.00	0.00	0.00	0.00
952	5917075001324	09/21/16 - 09/21/16	03/20/17	0.00	390.00	0.00	0.00	0.00
952	5917075001324	10/31/16 - 10/31/16	03/20/17	0.00	126.00	0.00	0.00	0.00
952	9717118951095	09/21/16 - 09/21/16	05/08/17	0.00	195.00	0.00	0.00	0.00
952	9717118951095	09/09/16 - 09/09/16	05/08/17	0.00	195.00	0.00	0.00	0.00
952	9717118951095	08/26/16 - 08/26/16	05/08/17	0.00	195.00	0.00	0.00	0.00
TOTAL				0.00	2,076.00	0.00	0.00	0.00

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 08/29/2018
Run Time: 00:55:14
Page: 20

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	04/01/16	THROUGH	03/31/17
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: 08/29/2018
 Run Time: 00:46:59
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,028,737.22	ADJUSTMENTS	1,923,630.06
COVERED CHARGES	30,497,619.33	CONTRACTUAL ALLOW	26,249,405.68
NON-COVERD CHARGES	531,117.89	TOTAL MEDICAID LIAB	4,248,213.65
		LESS: COB	71,600.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,176,613.36

TOTAL NUMBER OF ADMISSIONS 593

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,091		0	1,509,843.00		81,105.80
ROUTINE NURSERY	617		0	920,862.00		7,072.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,708		0	2,430,705.00		88,177.80
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	901		0	3,349,642.00		95,445.00
NICU	11		0	57,937.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	912		0	3,407,579.00		95,445.00
TOTAL ACCOMODATIONS	2,620		0	5,838,284.00		183,622.80

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,002,139.30	39,883.20	OTHER LAB	91,233.10	4,147.00
MED/SURG SUPPLY	3,344,105.60	42,547.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,384,841.38	23,871.17	EDUCATION & TRAINING	878.90	0.00
RADIOLOGY-DIAGNOSTIC	354,926.10	2,391.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,005,961.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	256,001.18	26,112.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	151,794.90	2,154.30	MRI SERVICES	154,240.10	0.00
IV THERAPY	20,266.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,533,619.60	6,759.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,293,146.60	0.00	REHAB THERAPY	249.00	0.00
RESPIRATORY SERVICES	1,319,017.10	6,297.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364,960.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	178,337.90	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	579,459.60	573.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	329,970.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	141,479.90	0.00	INJECTABLE DRUGS	0.00	525.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	78,521.23	23,617.92	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	222,595.74	26,435.90	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,743.30	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29,264.80	204.40	TRAUMA RESPONSE	0.00	23,785.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	838,331.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,533.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	118,188.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,840.70	0.00			
AUDIOLOGY	78,552.60	0.00			
CARDIOLOGY	530,140.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,085.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	104,097.00	0.00			
			TOTAL ANCILLARY	24,659,335.33	347,495.09
			TOTAL ACCOMODATIONS	5,838,284.00	183,622.80
			TOTAL CHARGES	30,497,619.33	531,117.89

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
 Run Time: 00:47:00
 Page: 3

SUMMARY TYPE II
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,006.10	ADJUSTMENTS	0.00
COVERED CHARGES	45,850.10	CONTRACTUAL ALLOW	34,223.29
NON-COVERD CHARGES	156.00	TOTAL MEDICAID LIAB	11,626.81
		LESS: COB	11,626.81
		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	3		0	4,167.00		156.00
ROUTINE NURSERY	3		0	2,232.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6		0	6,399.00		156.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	6,399.00		156.00

Report : CLM-0802-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
 Run Time: 00:47:00
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,948.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,401.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,738.50	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	13,652.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,032.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,008.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,614.70	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	227.80	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	826.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	39,451.10	0.00
			TOTAL ACCOMODATIONS	6,399.00	156.00
			TOTAL CHARGES	45,850.10	156.00

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: 08/29/2018
Run Time: 00:47:01
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,637,885.85	ADJUSTMENTS	158,225.65
COVERED CHARGES	7,202,349.94	CONTRACTUAL ALLOW	6,631,788.12
NON-COVERD CHARGES	435,535.91	TOTAL MEDICAID LIAB	570,561.82
		LESS: COB	353.57
		LESS: COPAYMENT	2,037.00
		REIMBURSEMENT	568,171.25
		ALL OTHER	512,810.57
		FEE SCHEDULE-LAB	45,610.97
		INJECTABLE DRUGS	9,749.71
		TOTAL NUMBER OF CLAIMS	1,608

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	398,435.50	3,477.50	OTHER LAB	47,373.00	0.00
MED/SURG SUPPLY	546,660.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	236,212.00	1,066.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	693,551.50	38,347.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,612.80	4,693.31	FEE SCHEDULE LAB	1,163,298.10	35,615.90
EKG/ECG	116,332.20	7,181.00	MRI SERVICES	214,758.80	16,389.30
IV THERAPY	451,420.70	12,245.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	287,986.33	38,706.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,856.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,397.70	0.00	AMBULANCE	0.00	1,499.10
GI SERVICES	40,076.40	6,578.10	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,208,439.80	1,703.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,138.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	834,251.10	122,214.70
RADIOLOGY THERAPEUTIC	33,187.70	2,794.60	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,975.40	3,335.42	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	21,288.20	2,150.40	TRAUMA RESPONSE	0.00	6,854.30
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,629.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	128,612.80	18,077.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	7,860.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	62,767.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	90,689.10	9,830.30			
AMBULATORY SURGERY	220,378.59	91,683.11			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,869.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	161,151.22	3,231.80			
			TOTAL ANCILLARY	7,202,349.94	435,535.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,202,349.94	435,535.91

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: 08/29/2018
Run Time: 00:47:04
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,013.80	ADJUSTMENTS	0.00
COVERED CHARGES	19,767.90	CONTRACTUAL ALLOW	17,114.35
NON-COVERD CHARGES	6,245.90	TOTAL MEDICAID LIAB	2,653.55
		LESS: COB	2,650.55
		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

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,486.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	768.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,738.20	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	6,113.90
IV THERAPY	1,392.60	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	7,894.00	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	2,487.60	132.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,767.90	6,245.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,767.90	6,245.90

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 NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	437,177.42	ADJUSTMENTS	217.76
COVERED CHARGES	415,597.80	CONTRACTUAL ALLOW	408,045.90
NON-COVERD CHARGES	21,579.62	TOTAL MEDICAID LIAB	7,551.90
		LESS: COB	0.00
		LESS: COPAYMENT	282.26
		REIMBURSEMENT	7,269.64
		TOTAL NUMBER OF CLAIMS	135

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,669.40	126.00	OTHER LAB	1,049.70	0.00
MED/SURG SUPPLY	10,262.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,998.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,385.60	3,531.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,807.82	FEE SCHEDULE LAB	80,084.00	1,441.50
EKG/ECG	10,771.50	2,154.30	MRI SERVICES	0.00	0.00
IV THERAPY	23,963.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,750.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	181,368.10	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	19,856.30	4,028.30
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	173.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,436.80	3,679.40			
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	4,638.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,000.80	0.00			
			TOTAL ANCILLARY	415,597.80	21,579.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	415,597.80	21,579.62

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 NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A
PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,987.30	ADJUSTMENTS	0.00
COVERED CHARGES	10,115.20	CONTRACTUAL ALLOW	8,947.11
NON-COVERD CHARGES	872.10	TOTAL MEDICAID LIAB	1,168.09
		LESS: COB	1,159.09
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VI
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	266.40	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	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,618.60	815.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,040.80	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	1,184.50	57.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,115.20	872.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,115.20	872.10

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC
3000 HOSPITAL BLVD
ROSWELL,GA 30076-4915

PROVIDER NUMBER
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,493,572.40	ADJUSTMENTS	26,610.00
COVERED CHARGES	1,351,566.87	CONTRACTUAL ALLOW	1,270,457.87
NON-COVERD CHARGES	142,005.53	TOTAL MEDICAID LIAB	81,109.00
		LESS: COB	0.00
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	80,746.00
		TOTAL NUMBER OF CLAIMS	15

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC
 3000 HOSPITAL BLVD
 ROSWELL,GA 30076-4915

PROVIDER NUMBER
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,358.00	2,774.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89,796.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,317.80	789.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	59,943.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	431.40	FEE SCHEDULE LAB	38,588.10	0.00
EKG/ECG	718.10	0.00	MRI SERVICES	5,154.40	0.00
IV THERAPY	116,685.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	69,680.77	22,530.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,633.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,266.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,541.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	635,023.30	111,321.70
RADIOLOGY THERAPEUTIC	1,817.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	798.90	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	407.00	0.00	TRAUMA RESPONSE	0.00	3,359.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	212,801.80	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	999.30	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	5,834.40	0.00			
			TOTAL ANCILLARY	1,351,566.87	142,005.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,351,566.87	142,005.53

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,335.80	ADJUSTMENTS	0.00
COVERED CHARGES	61,025.80	CONTRACTUAL ALLOW	51,505.89
NON-COVERD CHARGES	2,310.00	TOTAL MEDICAID LIAB	9,519.91
		LESS: COB	9,516.91
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE VIII

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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	510.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,209.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,923.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	718.40	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,555.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,896.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,008.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,547.70	1,799.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,166.50	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	61,025.80	2,310.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,025.80	2,310.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,819,672.20	ADJUSTMENTS	15,262.54
COVERED CHARGES	5,624,424.70	CONTRACTUAL ALLOW	4,290,973.74
NON-COVERD CHARGES	195,247.50	TOTAL MEDICAID LIAB	1,333,450.96
		LESS: COB	16,852.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,316,598.85

TOTAL NUMBER OF ADMISSIONS 159

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	417		0	403,656.00		125,053.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	417		0	403,656.00		125,053.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	81		0	196,631.25		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	81		0	196,631.25		0.00
TOTAL ACCOMODATIONS	498		0	600,287.25		125,053.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	418,495.14	0.00	OTHER LAB	32,372.50	0.00
MED/SURG SUPPLY	199,651.00	385.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,024,128.71	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	180,498.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	256,307.50	61,110.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	55,900.79	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	44,888.25	0.00	MRI SERVICES	48,148.25	0.00
IV THERAPY	41,562.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	642,190.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119,013.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	251,993.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,065.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	295,184.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	110,172.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	7,604.00
LABORATORY PATHOLOGIC	13,025.75	0.00	INJECTABLE DRUGS	699,689.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,949.89	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,362.63	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	22,803.75	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	770.00	349.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	276,849.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,935.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,510.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,970.75	745.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	139,513.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,673.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,510.51	0.00			
			TOTAL ANCILLARY	5,024,137.45	70,194.50
			TOTAL ACCOMODATIONS	600,287.25	125,053.00
			TOTAL CHARGES	5,624,424.70	195,247.50

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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,384,489.15	ADJUSTMENTS	15,155.04
COVERED CHARGES	7,802,738.46	CONTRACTUAL ALLOW	6,904,169.81
NON-COVERD CHARGES	581,750.69	TOTAL MEDICAID LIAB	898,568.65
		LESS: COB	589.13
		LESS: COPAYMENT	1,827.00
		REIMBURSEMENT	896,152.52
		ALL OTHER	827,620.03
		FEE SCHEDULE-LAB	64,652.67
		INJECTABLE DRUGS	3,879.82
		TOTAL NUMBER OF CLAIMS	2,200

COLISEUM NORTHSIDE HOSPITAL
 400 CHARTER BLVD
 MACON,GA 31210-4831

PROVIDER NUMBER
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,549.66	3,277.00	OTHER LAB	54,173.50	0.00
MED/SURG SUPPLY	96,938.75	1,154.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	776,622.00	2,997.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,237,347.25	234,082.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	98,874.00	71,410.53	FEE SCHEDULE LAB	1,519,629.67	12,101.25
EKG/ECG	116,042.50	0.00	MRI SERVICES	104,039.50	14,665.25
IV THERAPY	347,591.75	1,793.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	340,152.60	91,902.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,602.25	9,631.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	187,790.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	85,738.50	16,041.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,827,932.00	11,127.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	126,209.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,876.53	4,196.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,868.25	24,616.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,224.75	387.30	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,988.25	1,920.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,490.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	91,306.50	46,912.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,861.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	31,239.50	5,891.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,194.25	13,479.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	228,414.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	200,041.50	14,163.50			
			TOTAL ANCILLARY	7,802,738.46	581,750.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,802,738.46	581,750.69

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	215,471.00	ADJUSTMENTS	0.00
COVERED CHARGES	157,886.25	CONTRACTUAL ALLOW	117,542.49
NON-COVERD CHARGES	57,584.75	TOTAL MEDICAID LIAB	40,343.76
		LESS: COB	40,310.76
		LESS: COPAYMENT	33.00
		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

COLISEUM NORTHSIDE HOSPITAL
 400 CHARTER BLVD
 MACON,GA 31210-4831

PROVIDER NUMBER
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,173.25	0.00	OTHER LAB	1,715.00	0.00
MED/SURG SUPPLY	2,065.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,021.50	3,149.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,934.75	14,624.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37,523.50	2,054.25
EKG/ECG	2,979.50	0.00	MRI SERVICES	0.00	6,313.25
IV THERAPY	2,122.50	1,823.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	19,185.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,894.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,009.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,147.50	1,274.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,002.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	289.50	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	139.25	65.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,758.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,513.75	5,778.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,916.75	306.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,676.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,012.00	0.00			
			TOTAL ANCILLARY	157,886.25	57,584.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	157,886.25	57,584.75

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	794,975.50	ADJUSTMENTS	0.00
COVERED CHARGES	756,436.75	CONTRACTUAL ALLOW	736,298.35
NON-COVERD CHARGES	38,538.75	TOTAL MEDICAID LIAB	20,138.40
		LESS: COB	0.00
		LESS: COPAYMENT	690.00
		REIMBURSEMENT	19,448.40
		TOTAL NUMBER OF CLAIMS	360

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,969.25	1,175.50	OTHER LAB	1,715.00	0.00
MED/SURG SUPPLY	729.50	89.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	114,360.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,681.00	30,075.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	164,244.00	32.00
EKG/ECG	5,096.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,577.00	88.75	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	167.25	1,206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	333,062.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,173.75	360.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	131.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,661.25	5,380.50			
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	756,436.75	38,538.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	756,436.75	38,538.75

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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,891.75	ADJUSTMENTS	0.00
COVERED CHARGES	25,589.00	CONTRACTUAL ALLOW	14,879.94
NON-COVERD CHARGES	302.75	TOTAL MEDICAID LIAB	10,709.06
		LESS: COB	10,691.06
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214.00	214.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,737.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,327.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,448.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,367.75	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	10,115.75	88.75	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	377.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,589.00	302.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,589.00	302.75

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

COLISEUM NORTHSIDE HOSPITAL
400 CHARTER BLVD
MACON,GA 31210-4831

PROVIDER NUMBER
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	138,487.25	ADJUSTMENTS	0.00
COVERED CHARGES	133,712.00	CONTRACTUAL ALLOW	117,630.44
NON-COVERD CHARGES	4,775.25	TOTAL MEDICAID LIAB	16,081.56
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	16,075.56

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM NORTHSIDE HOSPITAL
 400 CHARTER BLVD
 MACON,GA 31210-4831

PROVIDER NUMBER
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,370.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,285.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	552.25	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	693.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,579.50	4,775.25	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	28,561.50	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	8,480.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,167.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	133,712.00	4,775.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	133,712.00	4,775.25

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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:47:13
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	897,902.96	ADJUSTMENTS	0.00
COVERED CHARGES	897,902.96	CONTRACTUAL ALLOW	673,395.70
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	224,507.26
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	224,507.26

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	102		0	99,144.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	102		0	99,144.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,815.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	1,815.00		0.00
TOTAL ACCOMODATIONS	103		0	100,959.00		0.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
 100 FRIST CT
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,713.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	70,666.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,361.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,358.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,798.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,696.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	408.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	240,762.96	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,923.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,899.28	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,492.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,579.00	0.00	INJECTABLE DRUGS	75,808.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,406.56	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,355.71	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	126.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	212,660.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,889.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,036.10	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	796,943.96	0.00
			TOTAL ACCOMODATIONS	100,959.00	0.00
			TOTAL CHARGES	897,902.96	0.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	798,921.99	ADJUSTMENTS	64.88
COVERED CHARGES	740,948.97	CONTRACTUAL ALLOW	600,654.87
NON-COVERD CHARGES	57,973.02	TOTAL MEDICAID LIAB	140,294.10
		LESS: COB	35.85
		LESS: COPAYMENT	567.00
		REIMBURSEMENT	139,691.25
		ALL OTHER	135,663.21
		FEE SCHEDULE-LAB	3,910.34
		INJECTABLE DRUGS	117.70

TOTAL NUMBER OF CLAIMS 159

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,589.37	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66,972.50	3,557.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,115.75	315.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,331.50	4,535.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,967.71	4,417.37	FEE SCHEDULE LAB	22,061.43	1,019.19
EKG/ECG	2,040.00	204.00	MRI SERVICES	16,223.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	255,716.33	25,298.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	582.69	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,757.84	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,000.00	6,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,698.37	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,151.75	1,517.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,526.13	1,941.77	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	55,888.75	0.00
LITHOTRIPSY	8,301.00	8,301.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,222.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,296.85	365.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	76,506.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	740,948.97	57,973.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	740,948.97	57,973.02

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

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,467.23	ADJUSTMENTS	0.00
COVERED CHARGES	25,424.73	CONTRACTUAL ALLOW	15,818.22
NON-COVERD CHARGES	8,042.50	TOTAL MEDICAID LIAB	9,606.51
		LESS: COB	9,603.51
		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

NORTHSIDE MEDICAL CENTER
 100 FRIST CT
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	182.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,303.00	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	733.75	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	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	1,556.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,800.00	8,022.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,424.73	8,042.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,424.73	8,042.50

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 MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE MEDICAL CENTER
100 FRIST CT
COLUMBUS,GA 31909-3578

PROVIDER NUMBER
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,674.12	ADJUSTMENTS	0.00
COVERED CHARGES	31,058.12	CONTRACTUAL ALLOW	25,552.12
NON-COVERD CHARGES	616.00	TOTAL MEDICAID LIAB	5,506.00
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	5,500.00
		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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	813.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,802.25	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	549.50	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,389.22	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,415.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,556.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	474.00	596.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,057.75	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	0.00	0.00			
			TOTAL ANCILLARY	31,058.12	616.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,058.12	616.00

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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
 Run Time: 00:55:46
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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 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,308.18	ADJUSTMENTS	0.00
COVERED CHARGES	94,675.18	CONTRACTUAL ALLOW	71,593.18
NON-COVERD CHARGES	9,633.00	TOTAL MEDICAID LIAB	23,082.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,082.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	48		7	45,636.00		9,633.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	48		7	45,636.00		9,633.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	48		7	45,636.00		9,633.00

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC
 1355 INDEPENDENCE DR
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 04/01/16 THROUGH 03/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,748.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	503.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	324.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,075.00	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	3,598.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	18,790.50	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	49,039.18	0.00
			TOTAL ACCOMODATIONS	45,636.00	9,633.00
			TOTAL CHARGES	94,675.18	9,633.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II
ZERO PAID INPATIENT PAID CLAIMS

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	04/01/16	THROUGH	03/31/17
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: 08/29/2018
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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 04/01/16 THROUGH 03/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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	04/01/16	THROUGH	03/31/17
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	04/01/16	THROUGH	03/31/17
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	04/01/16	THROUGH	03/31/17
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	04/01/16	THROUGH	03/31/17
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: 08/29/2018
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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	04/01/16	THROUGH	03/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

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 06/28/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,521,139.98	ADJUSTMENTS	80,348.32
COVERED CHARGES	2,259,523.00	CONTRACTUAL ALLOW	1,979,469.25
NON-COVERD CHARGES	261,616.98	TOTAL MEDICAID LIAB	280,053.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	280,053.75

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	346		0	606,192.00		261,616.98
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	346		0	606,192.00		261,616.98
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	7		0	23,225.16		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7		0	23,225.16		0.00
TOTAL ACCOMODATIONS	353		0	629,417.16		261,616.98

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 06/28/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	306,171.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	204,107.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	85,016.74	0.00	EDUCATION & TRAINING	10,683.66	0.00
RADIOLOGY-DIAGNOSTIC	12,069.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,062.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	123,761.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,800.16	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	733,556.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	905.58	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	102.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,194.18	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,671.38	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	102,872.03	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,130.87	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,630,105.84	0.00
			TOTAL ACCOMODATIONS	629,417.16	261,616.98
			TOTAL CHARGES	2,259,523.00	261,616.98

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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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	06/28/16	THROUGH	08/31/17
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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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 06/28/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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SUMMARY TYPE IV

Run Date: 08/29/2018
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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	06/28/16	THROUGH	08/31/17
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: 08/29/2018
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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	06/28/16	THROUGH	08/31/17
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 - 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	06/28/16	THROUGH	08/31/17
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 - 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	06/28/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	06/28/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
 35 JESSE HILL JR DR SE
 ATLANTA,GA 30303-3032

PROVIDER NUMBER 000679808A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,855,902.62	ADJUSTMENTS	101,374.24
COVERED CHARGES	7,814,542.72	CONTRACTUAL ALLOW	5,835,534.48
NON-COVERD CHARGES	41,359.90	TOTAL MEDICAID LIAB	1,979,008.24
		LESS: COB	8,249.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,970,758.61

TOTAL NUMBER OF ADMISSIONS 305

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	771		0	982,254.00		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	771		0	982,254.00		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	771		0	982,254.00		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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	540,624.00	0.00	OTHER LAB	7,912.00	0.00
MED/SURG SUPPLY	219,328.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	631,991.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	154,038.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,428.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,683.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,584.00	0.00	MRI SERVICES	47,151.82	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	2,209.20
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,203,520.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	915,132.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,504.00	0.00	INJECTABLE DRUGS	0.00	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	1,164.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	562.00	32,496.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,803.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	55,171.00	1,911.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,518.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,756.40	4,743.70			
			TOTAL ANCILLARY	6,832,288.72	41,359.90
			TOTAL ACCOMODATIONS	982,254.00	0.00
			TOTAL CHARGES	7,814,542.72	41,359.90

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
Run Time: 00:19:17
Page: 4

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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,496,082.21	ADJUSTMENTS	282,646.12
COVERED CHARGES	18,607,768.15	CONTRACTUAL ALLOW	14,780,217.36
NON-COVERD CHARGES	888,314.06	TOTAL MEDICAID LIAB	3,827,550.79
		LESS: COB	7,864.59
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	3,819,680.20
		ALL OTHER	3,364,198.01
		FEE SCHEDULE-LAB	148,605.84
		INJECTABLE DRUGS	306,876.35
		TOTAL NUMBER OF CLAIMS	10,498

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	269,998.50	6.50	OTHER LAB	429,261.00	4,074.00
MED/SURG SUPPLY	528,773.50	4,060.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543,956.00	14,305.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	83,882.00	3,846.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,908,243.00	232,981.50
EKG/ECG	36,926.00	0.00	MRI SERVICES	4,455.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,555.80
OPERATING ROOM	0.00	389.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	934,094.00	238,910.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,262,479.00	30,550.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,027,151.75	100,539.01
RADIOLOGY THERAPEUTIC	27,250.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,164.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,858,109.00	242,393.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	600.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,855.25
OTHER IMAGING SERVICE	147,550.00	7,947.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	373,698.00	1,911.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	660.00	90.00			
CARDIOLOGY	37,980.00	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	131,537.40	0.00			
			TOTAL ANCILLARY	18,607,768.15	888,314.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,607,768.15	888,314.06

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: 08/29/2018
Run Time: 00:19:17
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
970	2017299094851	09/22/17 - 09/22/17	10/30/17	0.00	951.75	0.00	0.00	0.00
970	2017340075633	10/02/17 - 10/02/17	12/11/17	0.00	951.75	0.00	0.00	0.00
970	2017362073758	07/10/17 - 07/10/17	01/01/18	0.00	951.75	0.00	0.00	0.00
TOTAL				0.00	2,855.25	0.00	0.00	0.00

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,811.50	ADJUSTMENTS	0.00
COVERED CHARGES	83,066.25	CONTRACTUAL ALLOW	51,030.75
NON-COVERD CHARGES	7,745.25	TOTAL MEDICAID LIAB	32,035.50
		LESS: COB	32,035.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 58

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,101.00	0.00	OTHER LAB	4,675.00	0.00
MED/SURG SUPPLY	2,220.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	984.00	3,236.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,656.00	676.00
EKG/ECG	382.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	396.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,260.00	1,011.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,689.00	200.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	259.25	150.25
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	14,699.00	2,076.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,111.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	30.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	83,066.25	7,745.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,066.25	7,745.25

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,211,865.50	ADJUSTMENTS	1,454.44
COVERED CHARGES	2,198,700.25	CONTRACTUAL ALLOW	2,122,358.81
NON-COVERD CHARGES	13,165.25	TOTAL MEDICAID LIAB	76,341.44
		LESS: COB	151.16
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	76,181.28
		TOTAL NUMBER OF CLAIMS	1,362

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,601.75	0.00	OTHER LAB	1,604.00	0.00
MED/SURG SUPPLY	35,453.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,147.00	1,871.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	234,527.00	1,069.75
EKG/ECG	4,584.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	594.00
OPERATING ROOM	1,242.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,777.00	4,668.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,767,854.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,027.50	3,268.50
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	2,153.00	447.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,200.00	1,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,330.00	0.00			
			TOTAL ANCILLARY	2,198,700.25	13,165.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,198,700.25	13,165.25

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,976.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,780.00	CONTRACTUAL ALLOW	4,119.48
NON-COVERD CHARGES	196.00	TOTAL MEDICAID LIAB	1,660.52
		LESS: COB	1,660.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

Report : CLM-0810-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	463.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	196.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,317.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,780.00	196.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,780.00	196.00

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: 08/29/2018
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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 01/01/17 THROUGH 12/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,291.00	ADJUSTMENTS	9,244.31
COVERED CHARGES	68,291.00	CONTRACTUAL ALLOW	31,313.76
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	36,977.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,977.24
		TOTAL NUMBER OF CLAIMS	4

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 01/01/17 THROUGH 12/31/17
 ADMISSION DATES 00/00/00 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	532.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	65,576.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,183.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	68,291.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,291.00	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: 08/29/2018
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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	01/01/17	THROUGH	12/31/17
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: 08/29/2018
 Run Time: 00:49:35
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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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,240.37	ADJUSTMENTS	0.00
COVERED CHARGES	52,945.92	CONTRACTUAL ALLOW	19,142.96
NON-COVERD CHARGES	7,294.45	TOTAL MEDICAID LIAB	33,802.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	33,802.96

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		0	6,912.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	6,912.00		0.00
SPECIAL CARE SERVICES						
CCU	11		0	7,260.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	7,260.00		0.00
TOTAL ACCOMODATIONS	23		0	14,172.00		0.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,270.52	3,410.59	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,158.17	142.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,112.00	45.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,500.00	1,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	416.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	128.00	128.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	48.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	387.29	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,415.00	2,252.60	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	1,044.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	342.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	68.00			
			TOTAL ANCILLARY	38,773.92	7,294.45
			TOTAL ACCOMODATIONS	14,172.00	0.00
			TOTAL CHARGES	52,945.92	7,294.45

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

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 07/01/16 THROUGH 06/30/17
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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	685,059.62	ADJUSTMENTS	14,358.50
COVERED CHARGES	648,453.58	CONTRACTUAL ALLOW	380,154.89
NON-COVERD CHARGES	36,606.04	TOTAL MEDICAID LIAB	268,298.69
		LESS: COB	1,200.41
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	266,756.28
		ALL OTHER	247,101.46
		FEE SCHEDULE-LAB	18,545.46
		INJECTABLE DRUGS	1,109.36

TOTAL NUMBER OF CLAIMS 585

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,411.52	2,174.46	OTHER LAB	11,832.32	0.00
MED/SURG SUPPLY	10,810.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,034.00	2,300.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,439.00	6,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,595.00	152.02	FEE SCHEDULE LAB	114,511.50	5,026.75
EKG/ECG	6,656.00	384.00	MRI SERVICES	8,175.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	48.00
OPERATING ROOM	29,135.46	1,507.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,377.05	1,800.46	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,357.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	243,999.87	6,183.22	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,912.85	5,648.29
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,544.00	1,798.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,348.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,275.00
OTHER IMAGING SERVICE	8,286.05	1,125.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,836.00	283.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,250.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,942.00	0.00			
			TOTAL ANCILLARY	648,453.58	36,606.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	648,453.58	36,606.04

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

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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2017150057088	05/22/17 - 05/22/17	06/05/17	0.00	1,275.00	0.00	0.00	0.00
TOTAL				0.00	1,275.00	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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,977.19	ADJUSTMENTS	0.00
COVERED CHARGES	4,554.31	CONTRACTUAL ALLOW	-1,487.70
NON-COVERD CHARGES	7,422.88	TOTAL MEDICAID LIAB	6,042.01
		LESS: COB	6,039.01
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	84.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	67.66	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	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,099.00	17.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,322.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	3,717.20	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,594.00	258.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	496.65	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,554.31	7,422.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,554.31	7,422.88

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: 08/29/2018
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,598.06	ADJUSTMENTS	47.00
COVERED CHARGES	44,982.96	CONTRACTUAL ALLOW	42,332.96
NON-COVERD CHARGES	3,615.10	TOTAL MEDICAID LIAB	2,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	2,566.00
		TOTAL NUMBER OF CLAIMS	53

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	960.53	72.78	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	262.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	447.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,996.00	1,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,047.00	720.00
EKG/ECG	256.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	356.58	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	25,356.62	129.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	572.00	1,365.32
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	729.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	44,982.96	3,615.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	44,982.96	3,615.10

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/29/2018
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Page: 11

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	07/01/16	THROUGH	06/30/17
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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,646,257.46	ADJUSTMENTS	2,116,336.84
COVERED CHARGES	31,127,487.12	CONTRACTUAL ALLOW	23,736,728.09
NON-COVERD CHARGES	1,518,770.34	TOTAL MEDICAID LIAB	7,390,759.03
		LESS: COB	86,605.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,304,153.26

TOTAL NUMBER OF ADMISSIONS 683

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,381		0	2,730,531.00		296,231.00
ROUTINE NURSERY	485		0	894,116.00		44,000.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,866		0	3,624,647.00		340,231.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	743		0	2,328,460.00		79,256.00
NICU	228		0	639,276.00		198,396.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	971		0	2,967,736.00		277,652.00
TOTAL ACCOMODATIONS	3,837		0	6,592,383.00		617,883.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL
 1255 HIGHWAY 54 W
 FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
 000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,818,511.93	160,321.19	OTHER LAB	231,132.00	5,119.00
MED/SURG SUPPLY	658,663.91	43,981.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,273,512.00	181,921.00	EDUCATION & TRAINING	18,009.00	0.00
RADIOLOGY-DIAGNOSTIC	606,367.00	6,037.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,062,855.00	22,758.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	332,653.57	5,544.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	310,800.00	2,220.00	MRI SERVICES	266,260.00	0.00
IV THERAPY	16,905.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,847,336.00	78,493.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	541,965.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,188,160.00	70,943.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	245,963.00	2,265.00	AMBULANCE	0.00	0.00
GI SERVICES	202,739.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,965,152.00	10,370.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	340,831.00	11,107.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	254,856.00	6,981.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	48,049.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	215,643.31	301.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	86,673.22	2,094.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	866,880.00	134,091.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41,323.00	3,569.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	275,979.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	248,322.00	5,398.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	372,760.00	115,322.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,761.00	25,999.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	932,446.00	4,457.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	45,926.00	1,596.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	101,669.80	0.00			
			TOTAL ANCILLARY	24,535,104.12	900,887.34
			TOTAL ACCOMODATIONS	6,592,383.00	617,883.00
			TOTAL CHARGES	31,127,487.12	1,518,770.34

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	948,697.11	ADJUSTMENTS	0.00
COVERED CHARGES	938,326.11	CONTRACTUAL ALLOW	362,494.01
NON-COVERD CHARGES	10,371.00	TOTAL MEDICAID LIAB	575,832.10
		LESS: COB	575,832.10
		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	58		0	66,990.00		6,728.00
ROUTINE NURSERY	8		0	11,770.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	66		0	78,760.00		6,728.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	20		0	61,632.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	20		0	61,632.00		0.00
TOTAL ACCOMODATIONS	86		0	140,392.00		6,728.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	284,012.97	0.00	OTHER LAB	5,023.00	0.00
MED/SURG SUPPLY	12,712.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	112,065.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,943.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,675.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,273.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,440.00	0.00	MRI SERVICES	7,611.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,914.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	24,348.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,129.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,173.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,421.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,467.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,966.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,511.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,873.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,312.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	135,450.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	836.00	255.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	702.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,639.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,924.00	3,388.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,992.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,596.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,926.00	0.00			
			TOTAL ANCILLARY	797,934.11	3,643.00
			TOTAL ACCOMODATIONS	140,392.00	6,728.00
			TOTAL CHARGES	938,326.11	10,371.00

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: 08/29/2018
Run Time: 00:47:40
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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,072,298.77	ADJUSTMENTS	196,632.21
COVERED CHARGES	14,892,005.15	CONTRACTUAL ALLOW	13,153,056.37
NON-COVERD CHARGES	3,180,293.62	TOTAL MEDICAID LIAB	1,738,948.78
		LESS: COB	43,332.27
		LESS: COPAYMENT	4,145.32
		REIMBURSEMENT	1,691,471.19
		ALL OTHER	1,525,465.81
		FEE SCHEDULE-LAB	120,243.32
		INJECTABLE DRUGS	45,762.06

TOTAL NUMBER OF CLAIMS 3,762

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283,288.46	2,760.08	OTHER LAB	196,416.00	4,674.00
MED/SURG SUPPLY	367,650.09	56,492.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	207.00
RADIOLOGY-DIAGNOSTIC	691,199.00	56,912.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,982,165.00	841,910.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,963.00	16,022.10	FEE SCHEDULE LAB	2,087,741.00	239,323.00
EKG/ECG	357,975.00	6,105.00	MRI SERVICES	168,210.00	31,809.00
IV THERAPY	157,549.00	1,932.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	745,809.00	221,402.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,533.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80,491.00	34,880.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	125,062.00	1,173.00	AMBULANCE	0.00	0.00
GI SERVICES	554,392.00	184,927.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,508,274.00	177,502.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	231,888.00	20,522.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	445,696.73	277,234.70
RADIOLOGY THERAPEUTIC	201,316.00	240,957.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,588.00	9,755.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,629.00	4,862.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	48,762.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	94,119.00	10,537.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,385.53	54,015.92
LITHOTRIPSY	56,264.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	379,707.00	289,705.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69,688.00	33,880.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	110,037.00	70,968.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	431,795.00	220,492.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	98,544.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	380,630.34	20,572.07			
			TOTAL ANCILLARY	14,892,005.15	3,180,293.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,892,005.15	3,180,293.62

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 FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	525,791.25	ADJUSTMENTS	0.00
COVERED CHARGES	357,404.90	CONTRACTUAL ALLOW	229,780.35
NON-COVERD CHARGES	168,386.35	TOTAL MEDICAID LIAB	127,624.55
		LESS: COB	127,513.92
		LESS: COPAYMENT	110.63
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 94

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,804.11	0.00	OTHER LAB	2,110.00	3,330.00
MED/SURG SUPPLY	6,613.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,502.00	1,110.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,889.00	78,815.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,065.00	3,654.00	FEE SCHEDULE LAB	59,296.00	3,234.00
EKG/ECG	9,990.00	0.00	MRI SERVICES	4,423.00	4,965.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,168.00	25,973.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	438.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,049.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	124,411.00	1,388.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,991.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,577.51	33,692.35
RADIOLOGY THERAPEUTIC	36,213.00	2,886.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,051.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,217.00	9,339.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,355.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,865.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,377.00	0.00			
			TOTAL ANCILLARY	357,404.90	168,386.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	357,404.90	168,386.35

Report : CLM-0808-0
Process : CLMJ0800
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 FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	679,903.43	ADJUSTMENTS	382.58
COVERED CHARGES	579,494.62	CONTRACTUAL ALLOW	563,188.08
NON-COVERD CHARGES	100,408.81	TOTAL MEDICAID LIAB	16,306.54
		LESS: COB	1,757.92
		LESS: COPAYMENT	307.20
		REIMBURSEMENT	14,241.42
		TOTAL NUMBER OF CLAIMS	261

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,836.10	260.00	OTHER LAB	15,580.00	1,558.00
MED/SURG SUPPLY	1,514.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,851.00	2,143.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,828.00	19,333.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	106,065.00	10,277.00
EKG/ECG	10,545.00	555.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,726.00	1,675.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	14,827.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,782.00	1,296.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	490.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,629.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,176.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	316,485.00	8,766.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,572.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,390.03	6,578.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,352.00	31,407.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,744.00	731.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	929.20	1,002.80			
			TOTAL ANCILLARY	579,494.62	100,408.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	579,494.62	100,408.81

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: 08/29/2018
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PIEDMONT FAYETTE HOSPITAL
1255 HIGHWAY 54 W
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,607.93	ADJUSTMENTS	0.00
COVERED CHARGES	34,756.93	CONTRACTUAL ALLOW	24,420.29
NON-COVERD CHARGES	5,851.00	TOTAL MEDICAID LIAB	10,336.64
		LESS: COB	10,312.64
		LESS: COPAYMENT	24.00
		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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144.81	0.00	OTHER LAB	3,116.00	1,558.00
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	1,958.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,874.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,843.00	120.00
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	18,754.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,093.00	1,299.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,756.93	5,851.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,756.93	5,851.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,618,332.52	ADJUSTMENTS	31,967.88
COVERED CHARGES	1,336,637.67	CONTRACTUAL ALLOW	1,203,238.17
NON-COVERD CHARGES	281,694.85	TOTAL MEDICAID LIAB	133,399.50
		LESS: COB	0.00
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	133,165.50

TOTAL NUMBER OF CLAIMS 25

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,432.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,505.88	7,013.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,231.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,176.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,306.00	1,619.00
EKG/ECG	1,110.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	20,115.00	2,267.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,698.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,313.00	193.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,534.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,472.00	2,654.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,509.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	929,254.61	213,683.70
RADIOLOGY THERAPEUTIC	103,427.00	4,315.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	562.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	255.00	209.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,548.80	22,260.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,782.00	3,388.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,120.00	413.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	35,752.00	20,583.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,095.97	2,535.00			
			TOTAL ANCILLARY	1,336,637.67	281,694.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,336,637.67	281,694.85

Report : 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: 08/29/2018
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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	07/01/16	THROUGH	06/30/17
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: 08/29/2018
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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL, LLC
 320 TURNER MCCALL BLVD SW
 ROME,GA 30165-5621

PROVIDER NUMBER 000886179A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,239,566.87	ADJUSTMENTS	85,937.93
COVERED CHARGES	5,130,098.87	CONTRACTUAL ALLOW	4,156,445.62
NON-COVERD CHARGES	1,109,468.00	TOTAL MEDICAID LIAB	973,653.25
		LESS: COB	2,963.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	970,689.31

TOTAL NUMBER OF ADMISSIONS 37

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	225		191	597,825.00		830,719.00
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	225		191	597,825.00		830,719.00
SPECIAL CARE SERVICES						
CCU	447		0	1,745,583.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	447		0	1,745,583.00		0.00
TOTAL ACCOMODATIONS	672		191	2,343,408.00		830,719.00

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

THE SPECIALTY HOSPITAL, LLC
 320 TURNER MCCALL BLVD SW
 ROME,GA 30165-5621

PROVIDER NUMBER
 000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	980,092.20	11,745.50	OTHER LAB	3,464.00	0.00
MED/SURG SUPPLY	100,086.00	598.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	622,196.00	29,871.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,327.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,224.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,059.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,632.62	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	641,061.00	236,534.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,468.00	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	79,550.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	84,883.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,869.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,135.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,450.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,832.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,922.00	0.00			
			TOTAL ANCILLARY	2,786,690.87	278,749.00
			TOTAL ACCOMODATIONS	2,343,408.00	830,719.00
			TOTAL CHARGES	5,130,098.87	1,109,468.00

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, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

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THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0806-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0808-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE V
OUTPATIENT PAID CLAIMS - FIXED FEE

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THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
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

THE SPECIALTY HOSPITAL, LLC
320 TURNER MCCALL BLVD SW
ROME,GA 30165-5621

PROVIDER NUMBER
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/16	THROUGH	08/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

Report : CLM-0800-0
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 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

CHI MEMORIAL HOSPITAL - GEORGIA
 100 GROSS CRESCENT CIRCLE
 FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER 003180661A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/29/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	434,084.24	ADJUSTMENTS	0.00
COVERED CHARGES	434,084.24	CONTRACTUAL ALLOW	299,097.66
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	134,986.58
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	134,986.58

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	59		0	61,242.00		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	59		0	61,242.00		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	59		0	61,242.00		0.00

Report : CLM-0800-0
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GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I
 INPATIENT PAID CLAIMS

CHI MEMORIAL HOSPITAL - GEORGIA
 100 GROSS CRESCENT CIRCLE
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/29/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,454.24	0.00	OTHER LAB	1,522.00	0.00
MED/SURG SUPPLY	7,943.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	93,692.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,369.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,602.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,307.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,165.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,937.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,661.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,333.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	234.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,623.00	0.00			
			TOTAL ANCILLARY	372,842.24	0.00
			TOTAL ACCOMODATIONS	61,242.00	0.00
			TOTAL CHARGES	434,084.24	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

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/29/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

Report : CLM-0804-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
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SUMMARY TYPE III
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/29/2018
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CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/29/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,728,531.38	ADJUSTMENTS	5,533.06
COVERED CHARGES	3,454,887.44	CONTRACTUAL ALLOW	2,726,643.74
NON-COVERD CHARGES	273,643.94	TOTAL MEDICAID LIAB	728,243.70
		LESS: COB	1,906.76
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	726,324.94
		ALL OTHER	658,938.07
		FEE SCHEDULE-LAB	60,559.70
		INJECTABLE DRUGS	6,827.17
		TOTAL NUMBER OF CLAIMS	1,376

CHI MEMORIAL HOSPITAL - GEORGIA
 100 GROSS CRESCENT CIRCLE
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/29/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,878.78	1,676.90	OTHER LAB	11,582.00	0.00
MED/SURG SUPPLY	3,456.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	126,225.00	69,555.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	472,699.00	18,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,684.02	FEE SCHEDULE LAB	767,482.41	58,805.00
EKG/ECG	90,170.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	347,954.00	65,032.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,419.00	6,304.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,370,426.00	4,004.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	107,198.25	40,240.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	468.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	5,750.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,891.00	761.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,444.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,062.00	1,075.00			
			TOTAL ANCILLARY	3,454,887.44	273,643.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,454,887.44	273,643.94

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/29/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,057.64	ADJUSTMENTS	0.00
COVERED CHARGES	9,825.84	CONTRACTUAL ALLOW	6,673.13
NON-COVERD CHARGES	231.80	TOTAL MEDICAID LIAB	3,152.71
		LESS: COB	3,152.71
		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

CHI MEMORIAL HOSPITAL - GEORGIA
 100 GROSS CRESCENT CIRCLE
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/29/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,314.72	108.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,660.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,736.00	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	862.62	123.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,825.84	231.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,825.84	231.80

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: 08/29/2018
Run Time: 00:27:32
Page: 8

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/29/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	225,392.94	ADJUSTMENTS	0.00
COVERED CHARGES	221,177.45	CONTRACTUAL ALLOW	213,401.79
NON-COVERD CHARGES	4,215.49	TOTAL MEDICAID LIAB	7,775.66
		LESS: COB	0.00
		LESS: COPAYMENT	292.81
		REIMBURSEMENT	7,482.85
		TOTAL NUMBER OF CLAIMS	139

SUMMARY TYPE V
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHI MEMORIAL HOSPITAL - GEORGIA
 100 GROSS CRESCENT CIRCLE
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/29/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,386.85	41.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,364.00	700.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,884.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,231.00	3,206.00
EKG/ECG	2,485.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,780.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,632.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	114,695.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,197.60	268.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,522.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	221,177.45	4,215.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	221,177.45	4,215.49

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/29/2018
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CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 01/01/17 THROUGH 12/29/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,137.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,750.00	CONTRACTUAL ALLOW	1,628.79
NON-COVERD CHARGES	387.00	TOTAL MEDICAID LIAB	3,121.21
		LESS: COB	3,118.21
		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: 08/29/2018
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHI MEMORIAL HOSPITAL - GEORGIA
 100 GROSS CRESCENT CIRCLE
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER
 003180661A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 01/01/17 THROUGH 12/29/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	121.00	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	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	202.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	3,736.00	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	0.00	387.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,750.00	387.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,750.00	387.00

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

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/29/17
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: 08/29/2018
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHI MEMORIAL HOSPITAL - GEORGIA
100 GROSS CRESCENT CIRCLE
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER
003180661A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/17	THROUGH	12/29/17
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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,011,054.65	ADJUSTMENTS	271,075.08
COVERED CHARGES	8,809,809.58	CONTRACTUAL ALLOW	6,235,381.99
NON-COVERD CHARGES	201,245.07	TOTAL MEDICAID LIAB	2,574,427.59
		LESS: COB	68,836.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,505,590.87

TOTAL NUMBER OF ADMISSIONS 235

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,088		0	1,541,133.00		52,468.00
ROUTINE NURSERY	86		0	119,370.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,174		0	1,660,503.00		52,468.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	138		0	773,958.00		35,100.00
NICU	116		0	437,784.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	254		0	1,211,742.00		35,100.00
TOTAL ACCOMODATIONS	1,428		0	2,872,245.00		87,568.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,917.10	28,201.71	OTHER LAB	28,512.00	0.00
MED/SURG SUPPLY	299,053.12	3,505.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,144,204.68	12,198.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	145,363.02	1,550.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	363,524.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	146,315.73	3,648.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	27,099.00	1,606.00	MRI SERVICES	120,905.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	784,021.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	93,355.00	354.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	202,637.00	6,114.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	168,748.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	98,568.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	263,231.00	538.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	120,671.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	774.32
LABORATORY PATHOLOGIC	66,912.00	0.00	INJECTABLE DRUGS	688,690.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	83,899.79	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,867.47	3,309.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	169,204.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	179,709.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	30,901.00
OTHER IMAGING SERVICE	31,570.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,013.00	2,941.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,165.00	18,037.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	228,217.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,892.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,300.00	0.00			
			TOTAL ANCILLARY	5,937,564.58	113,677.07
			TOTAL ACCOMODATIONS	2,872,245.00	87,568.00
			TOTAL CHARGES	8,809,809.58	201,245.07

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE I
 INPATIENT PAID CLAIMS

Run Date: 08/29/2018
 Run Time: 00:25:25
 Page: 3

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2317058000206	01/13/17 - 01/20/17	03/20/17	0.00	4,265.00	0.00	6,588.47	0.00
615	2017090074862	03/20/17 - 03/21/17	04/10/17	0.00	2,569.00	0.00	0.00	0.00
614	2317191000159	03/22/17 - 03/29/17	07/24/17	0.00	4,265.00	0.00	2,191.85	0.00
614	2317191000159	03/22/17 - 03/29/17	07/24/17	0.00	4,265.00	0.00	2,191.85	0.00
618	2317191000159	03/22/17 - 03/29/17	07/24/17	0.00	6,134.00	0.00	2,191.85	0.00
614	2017244089543	05/10/17 - 05/21/17	09/11/17	0.00	4,265.00	0.00	0.00	0.00
614	2018208060256	11/25/16 - 12/20/16	08/06/18	0.00	5,138.00	0.00	0.00	0.00
TOTAL				0.00	30,901.00	0.00	13,164.02	0.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,069.11	ADJUSTMENTS	0.00
COVERED CHARGES	59,745.11	CONTRACTUAL ALLOW	25,968.89
NON-COVERD CHARGES	324.00	TOTAL MEDICAID LIAB	33,776.22
		LESS: COB	33,776.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	12,825.00		324.00
ROUTINE NURSERY	1		0	1,086.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	13,911.00		324.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	4		0	15,096.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	15,096.00		0.00
TOTAL ACCOMODATIONS	14		0	29,007.00		324.00

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	615.14	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	367.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,401.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,928.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	542.00	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	354.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,806.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,609.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	115.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,738.11	0.00
			TOTAL ACCOMODATIONS	29,007.00	324.00
			TOTAL CHARGES	59,745.11	324.00

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: 08/29/2018
Run Time: 00:25:26
Page: 6

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,178,563.80	ADJUSTMENTS	62,340.70
COVERED CHARGES	1,825,985.88	CONTRACTUAL ALLOW	1,469,314.78
NON-COVERD CHARGES	352,577.92	TOTAL MEDICAID LIAB	356,671.10
		LESS: COB	104.93
		LESS: COPAYMENT	996.00
		REIMBURSEMENT	355,570.17
		ALL OTHER	325,682.82
		FEE SCHEDULE-LAB	23,705.23
		INJECTABLE DRUGS	6,182.12

TOTAL NUMBER OF CLAIMS 682

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,048.57	18,142.12	OTHER LAB	16,038.00	0.00
MED/SURG SUPPLY	40,399.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,857.00	1,883.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	266,795.00	49,333.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,773.00	8,454.05	FEE SCHEDULE LAB	237,856.00	5,698.00
EKG/ECG	14,746.00	730.00	MRI SERVICES	120,118.00	30,778.00
IV THERAPY	685.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	207,371.00	64,125.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,500.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,137.00	1,995.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,569.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	22,074.00	15,963.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	294,099.00	7,720.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,666.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	92,900.31	13,533.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,226.00	8,768.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,535.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,971.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,174.00	884.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,737.00	11,766.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	74,740.00	30,141.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,999.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,148.00	35,274.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	122,261.00	38,064.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,040.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,029.00	2,820.00			
			TOTAL ANCILLARY	1,825,985.88	352,577.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,825,985.88	352,577.92

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

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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,561.54	ADJUSTMENTS	0.00
COVERED CHARGES	63,222.39	CONTRACTUAL ALLOW	17,791.73
NON-COVERD CHARGES	38,339.15	TOTAL MEDICAID LIAB	45,430.66
		LESS: COB	45,375.86
		LESS: COPAYMENT	54.80
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

SUMMARY TYPE IV
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	484.17	348.96	OTHER LAB	891.00	0.00
MED/SURG SUPPLY	2,968.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,021.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,370.00	12,833.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,441.00	861.00
EKG/ECG	292.00	0.00	MRI SERVICES	0.00	2,569.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,264.00	11,394.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	225.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,481.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,400.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,523.00	1,269.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,589.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,965.22	734.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,185.00	329.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,485.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,395.00	1,405.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,655.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,643.00	541.00			
			TOTAL ANCILLARY	63,222.39	38,339.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,222.39	38,339.15

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: 08/29/2018
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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 09/01/16 THROUGH 08/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,424.22	ADJUSTMENTS	0.00
COVERED CHARGES	21,136.42	CONTRACTUAL ALLOW	20,185.44
NON-COVERD CHARGES	3,287.80	TOTAL MEDICAID LIAB	950.98
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	923.98

TOTAL NUMBER OF CLAIMS 17

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 09/01/16 THROUGH 08/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164.50	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	729.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,882.00	2,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,005.00	197.00
EKG/ECG	292.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,888.00	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	163.92	257.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	369.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,136.42	3,287.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,136.42	3,287.80

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: 08/29/2018
Run Time: 00:25:29
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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	09/01/16	THROUGH	08/31/17
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: 08/29/2018
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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	09/01/16	THROUGH	08/31/17
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: 08/29/2018
Run Time: 00:25:29
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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	09/01/16	THROUGH	08/31/17
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: 09/05/2018
 Run Time: 19:15:06
 Page: 1

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
 903 N COURT ST
 QUITMAN,GA 31643-1315

PROVIDER NUMBER 000000239A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	202,014.20	ADJUSTMENTS	0.00
COVERED CHARGES	199,295.20	CONTRACTUAL ALLOW	109,764.67
NON-COVERD CHARGES	2,719.00	TOTAL MEDICAID LIAB	89,530.53
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	89,530.53

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	51		0	31,329.00		843.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	51		0	31,329.00		843.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	51		0	31,329.00		843.00

Report : CLM-0800-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/05/2018
 Run Time: 19:15:06
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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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,924.20	0.00	OTHER LAB	581.00	0.00
MED/SURG SUPPLY	7,335.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	54,335.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,775.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,657.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,604.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,478.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,877.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,560.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	254.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	511.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	627.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,138.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,016.00	1,876.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,735.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	559.00	0.00			
			TOTAL ANCILLARY	167,966.20	1,876.00
			TOTAL ACCOMODATIONS	31,329.00	843.00
			TOTAL CHARGES	199,295.20	2,719.00

Report : CLM-0802-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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	10/01/16	THROUGH	09/30/17
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: 09/05/2018
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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,542,296.27	ADJUSTMENTS	32,803.77
COVERED CHARGES	1,442,814.74	CONTRACTUAL ALLOW	1,086,597.66
NON-COVERD CHARGES	99,481.53	TOTAL MEDICAID LIAB	356,217.08
		LESS: COB	0.00
		LESS: COPAYMENT	1,191.00
		REIMBURSEMENT	355,026.08
		ALL OTHER	301,501.48
		FEE SCHEDULE-LAB	49,378.55
		INJECTABLE DRUGS	4,146.05

TOTAL NUMBER OF CLAIMS 1,499

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	264,401.47	70.00	OTHER LAB	4,410.00	0.00
MED/SURG SUPPLY	12,841.00	414.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,455.00	1,894.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	184,245.00	30,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	69,926.00	36,188.00	FEE SCHEDULE LAB	426,415.00	13,892.00
EKG/ECG	11,040.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	71,083.00	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	10,934.00	1,805.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	229,284.00	3,651.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,243.27	2,095.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,887.00	7,634.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	979.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,716.00	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	14,391.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,543.00	0.00			
			TOTAL ANCILLARY	1,442,814.74	99,481.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,442,814.74	99,481.53

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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,864.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,864.00	CONTRACTUAL ALLOW	1,127.93
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,736.07
		LESS: COB	1,736.07
		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

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	55.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	361.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,087.00	0.00
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	1,184.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,864.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,864.00	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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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,593.08	ADJUSTMENTS	194.00
COVERED CHARGES	42,218.08	CONTRACTUAL ALLOW	38,518.08
NON-COVERD CHARGES	375.00	TOTAL MEDICAID LIAB	3,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	3,628.00
		TOTAL NUMBER OF CLAIMS	74

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	734.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,346.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,120.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,681.00	111.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,093.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	362.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,807.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,086.08	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	0.00	TRAUMA RESPONSE	0.00	0.00
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	603.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,218.08	375.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,218.08	375.00

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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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 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,330.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,316.00	CONTRACTUAL ALLOW	986.14
NON-COVERD CHARGES	14.00	TOTAL MEDICAID LIAB	329.86
		LESS: COB	329.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 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	744.00	14.00
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	301.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	94.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,316.00	14.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,316.00	14.00

Report : CLM-0812-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 N COURT ST
QUITMAN,GA 31643-1315

PROVIDER NUMBER
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 10/01/16 THROUGH 09/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	212,757.00	ADJUSTMENTS	9,716.78
COVERED CHARGES	208,805.00	CONTRACTUAL ALLOW	184,490.55
NON-COVERD CHARGES	3,952.00	TOTAL MEDICAID LIAB	24,314.45
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	24,296.45

TOTAL NUMBER OF CLAIMS 5

Report : CLM-0812-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/05/2018
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SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
 903 N COURT ST
 QUITMAN,GA 31643-1315

PROVIDER NUMBER
 000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 10/01/16 THROUGH 09/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189,388.00	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	333.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,084.00	3,952.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	208,805.00	3,952.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	208,805.00	3,952.00

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: 09/05/2018
Run Time: 19:15:57
Page: 14

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	10/01/16	THROUGH	09/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

GWINNETT MEDICAL CENTER
 1000 MEDICAL CENTER BLVD
 LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER 000000294A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	87,402,008.55	ADJUSTMENTS	1,768,964.57
COVERED CHARGES	82,474,922.55	CONTRACTUAL ALLOW	58,584,860.26
NON-COVERD CHARGES	4,927,086.00	TOTAL MEDICAID LIAB	23,890,062.29
		LESS: COB	455,116.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,434,945.41

TOTAL NUMBER OF ADMISSIONS 3,457

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,778		5	13,225,432.00		4,049,353.00
ROUTINE NURSERY	4,400		0	7,323,631.00		21,024.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,178		5	20,549,063.00		4,070,377.00
SPECIAL CARE SERVICES						
CCU	73		0	301,897.00		0.00
ICU	1,428		0	4,607,979.00		20,028.00
NICU	211		0	788,085.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	228		0	1,160,748.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,940		0	6,858,709.00		20,028.00
TOTAL ACCOMODATIONS	15,118		5	27,407,772.00		4,090,405.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,746,294.42	2,624.00	OTHER LAB	632,007.00	1,927.00
MED/SURG SUPPLY	521,924.00	34,489.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,916,160.00	5,030.00	EDUCATION & TRAINING	12,140.00	0.00
RADIOLOGY-DIAGNOSTIC	2,388,950.00	1,320.00	OTHER THERAPEUTIC SVC	2,476.00	0.00
CT SCAN	5,006,357.00	187,092.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	382,949.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	697,372.00	836.00	MRI SERVICES	834,280.00	0.00
IV THERAPY	1,197,284.00	722.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,296,429.00	26,906.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	541,957.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,850,572.00	13,297.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,436,876.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	297,171.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,269,806.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,488,998.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	499,734.00	0.00	INJECTABLE DRUGS	4,220,283.66	1,117.00
RADIOLOGY THERAPEUTIC	0.00	378.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	161,038.03	294.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	127,879.38	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,091,060.00	58,858.00	PATIENT CONVENIENCE	0.00	855.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,949.00	3,501.00	TRAUMA RESPONSE	0.00	214,500.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,279,727.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	158,242.00
OTHER IMAGING SERVICE	496,703.00	11,589.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	504,561.00	105,658.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	510,651.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,937,031.00	6,086.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	128,635.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	587,896.00	1,360.00			
			TOTAL ANCILLARY	55,067,150.55	836,681.00
			TOTAL ACCOMODATIONS	27,407,772.00	4,090,405.00
			TOTAL CHARGES	82,474,922.55	4,927,086.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016202007714	07/04/16 - 07/07/16	07/25/16	0.00	2,481.00	0.00	0.00	0.00
615	2016223080567	07/22/16 - 08/02/16	08/15/16	0.00	4,565.00	0.00	0.00	0.00
615	2316236000136	07/14/16 - 07/20/16	09/26/16	0.00	4,565.00	0.00	736.54	0.00
615	2016236073343	08/05/16 - 08/13/16	08/29/16	0.00	4,565.00	0.00	0.00	0.00
615	2016238005329	08/14/16 - 08/15/16	08/29/16	0.00	4,565.00	0.00	0.00	0.00
615	2316243000051	07/04/16 - 07/06/16	10/03/16	0.00	4,565.00	0.00	1,200.31	0.00
615	2316251000070	07/07/16 - 07/14/16	10/10/16	0.00	2,481.00	0.00	1,215.35	0.00
615	2316291000230	08/10/16 - 08/11/16	11/21/16	0.00	4,565.00	0.00	705.10	0.00
615	2316292000244	07/27/16 - 08/06/16	11/21/16	0.00	2,481.00	0.00	1,745.18	0.00
615	2016303006468	10/07/16 - 10/18/16	11/07/16	0.00	4,565.00	0.00	0.00	0.00
615	2216314000687	10/06/16 - 10/22/16	11/14/16	0.00	4,565.00	0.00	0.00	0.00
615	2016316008147	10/20/16 - 10/28/16	11/14/16	0.00	4,565.00	0.00	0.00	0.00
615	2016333032827	11/19/16 - 11/20/16	12/05/16	0.00	2,481.00	0.00	0.00	0.00
615	2317017000042	12/05/16 - 12/08/16	02/20/17	0.00	2,481.00	0.00	846.44	0.00
615	2217023008348	01/03/17 - 01/06/17	01/30/17	0.00	4,565.00	0.00	0.00	0.00
615	2017031069068	09/13/16 - 09/15/16	02/06/17	0.00	4,565.00	0.00	0.00	0.00
615	2017069008859	02/13/17 - 02/17/17	03/13/17	0.00	4,565.00	0.00	0.00	0.00
615	2317073000098	09/24/16 - 09/28/16	03/27/17	0.00	4,565.00	0.00	0.00	0.00
615	2317073000137	12/01/16 - 12/08/16	04/03/17	0.00	4,565.00	0.00	0.00	0.00
615	2317075000252	10/12/16 - 10/19/16	04/03/17	0.00	4,565.00	0.00	0.00	0.00
615	2017082108437	10/18/16 - 10/20/16	03/27/17	0.00	4,565.00	0.00	0.00	0.00
615	2317095000379	08/12/16 - 08/24/16	05/15/17	0.00	4,565.00	0.00	1,366.80	0.00
615	2017101009690	04/02/17 - 04/03/17	04/17/17	0.00	4,565.00	0.00	0.00	0.00
615	2017101074320	03/14/17 - 03/16/17	04/17/17	0.00	4,565.00	0.00	0.00	0.00
615	2217107004448	11/27/16 - 01/09/17	04/24/17	0.00	2,481.00	0.00	0.00	0.00
615	2017117093717	04/02/17 - 04/06/17	05/01/17	0.00	4,565.00	0.00	0.00	0.00
615	5917118001870	03/14/17 - 03/24/17	05/08/17	0.00	7,046.00	0.00	0.00	0.00
615	2317121000182	03/12/17 - 03/18/17	06/05/17	0.00	4,565.00	0.00	1,185.49	0.00
615	2017125007526	11/11/16 - 11/12/16	05/08/17	0.00	2,481.00	0.00	0.00	0.00
615	2017133005129	02/10/17 - 02/20/17	05/22/17	0.00	2,481.00	0.00	0.00	0.00
615	2017136079372	04/12/17 - 04/28/17	05/22/17	0.00	4,565.00	0.00	0.00	0.00
618	2317152000197	12/09/16 - 12/11/16	06/19/17	0.00	3,528.00	0.00	0.00	0.00
615	2217177005855	06/11/17 - 06/15/17	07/03/17	0.00	4,565.00	0.00	0.00	0.00
615	2317192000238	05/05/17 - 05/08/17	08/07/17	0.00	4,565.00	0.00	543.77	0.00
615	2317229000296	05/18/17 - 05/22/17	09/04/17	0.00	4,565.00	0.00	0.00	0.00
615	2017250100112	04/05/17 - 04/07/17	09/11/17	0.00	4,565.00	0.00	0.00	0.00
615	2017268030122	06/22/17 - 06/25/17	10/02/17	0.00	4,565.00	0.00	0.00	0.00
615	2317311000092	01/08/17 - 01/20/17	12/11/17	0.00	4,565.00	0.00	3,472.41	0.00
TOTAL				0.00	158,242.00	0.00	13,017.39	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: 09/05/2018
 Run Time: 19:18:09
 Page: 4

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,536,918.93	ADJUSTMENTS	0.00
COVERED CHARGES	1,461,335.93	CONTRACTUAL ALLOW	766,092.54
NON-COVERD CHARGES	75,583.00	TOTAL MEDICAID LIAB	695,243.39
		LESS: COB	695,243.39
		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	108		0	161,249.00		69,594.00
ROUTINE NURSERY	135		0	307,126.00		736.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	243		0	468,375.00		70,330.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	28		0	90,696.00		0.00
NICU	9		0	33,615.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	37		0	124,311.00		0.00
TOTAL ACCOMODATIONS	280		0	592,686.00		70,330.00

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,856.00	0.00	OTHER LAB	5,348.00	0.00
MED/SURG SUPPLY	9,687.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	83,115.00	0.00	EDUCATION & TRAINING	74.00	0.00
RADIOLOGY-DIAGNOSTIC	54,391.00	0.00	OTHER THERAPEUTIC SVC	1,238.00	0.00
CT SCAN	40,119.00	5,253.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,116.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,524.00	0.00	MRI SERVICES	2,849.00	0.00
IV THERAPY	5,556.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	123,613.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,688.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	99,757.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,801.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,164.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,982.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,068.00	0.00	INJECTABLE DRUGS	49,978.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,071.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,329.02	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	57,594.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,492.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,254.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	99,583.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,482.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,920.00	0.00			
			TOTAL ANCILLARY	868,649.93	5,253.00
			TOTAL ACCOMODATIONS	592,686.00	70,330.00
			TOTAL CHARGES	1,461,335.93	75,583.00

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: 09/05/2018
Run Time: 19:18:12
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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,078,468.45	ADJUSTMENTS	931,929.95
COVERED CHARGES	25,774,659.34	CONTRACTUAL ALLOW	21,149,156.36
NON-COVERD CHARGES	3,303,809.11	TOTAL MEDICAID LIAB	4,625,502.98
		LESS: COB	8,356.52
		LESS: COPAYMENT	11,807.63
		REIMBURSEMENT	4,605,338.83
		ALL OTHER	3,372,802.84
		FEE SCHEDULE-LAB	250,528.44
		INJECTABLE DRUGS	982,007.55

TOTAL NUMBER OF CLAIMS 9,012

Report : CLM-0804-0
 Process : CLMJ0800
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
 SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/05/2018
 Run Time: 19:18:12
 Page: 7

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	490,425.48	586.00	OTHER LAB	270,509.00	1,722.00
MED/SURG SUPPLY	67,148.00	32,992.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	742.00
RADIOLOGY-DIAGNOSTIC	1,165,715.00	32,667.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,279,718.00	558,009.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	88,994.00	19,107.15	FEE SCHEDULE LAB	2,348,405.00	100,846.00
EKG/ECG	481,287.00	4,180.00	MRI SERVICES	312,258.00	126,098.00
IV THERAPY	1,786,143.00	53,808.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,014,276.76	412,153.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,567.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,938.00	27,262.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	585,981.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	193,359.00	35,604.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,433,137.00	15,827.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	592,631.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,401,057.10	547,311.60
RADIOLOGY THERAPEUTIC	0.00	3,402.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,651.00	11,792.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	724.00	7,873.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	116,435.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	162,450.00	7,397.00	TRAUMA RESPONSE	0.00	51,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,696.00	440,430.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	41,085.00
OTHER IMAGING SERVICE	954,837.00	138,586.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,678.00	6,936.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	617,961.00	240,654.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	959,729.00	265,921.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,632.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	394,752.00	3,383.00			
			TOTAL ANCILLARY	25,774,659.34	3,303,809.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,774,659.34	3,303,809.11

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016238010181	07/20/16 - 07/20/16	08/29/16	0.00	2,481.00	0.00	0.00	0.00
615	2016238010181	07/20/16 - 07/20/16	08/29/16	0.00	2,084.00	0.00	0.00	0.00
615	2017016030248	11/17/16 - 11/17/16	01/23/17	0.00	2,481.00	0.00	0.00	0.00
615	2017016030248	11/17/16 - 11/17/16	01/23/17	0.00	2,084.00	0.00	0.00	0.00
615	2017131002589	04/13/17 - 04/13/17	05/15/17	0.00	2,481.00	0.00	0.00	0.00
615	2017131002589	04/13/17 - 04/13/17	05/15/17	0.00	2,084.00	0.00	0.00	0.00
615	2017153004840	05/02/17 - 05/02/17	06/05/17	0.00	2,481.00	0.00	0.00	0.00
615	2017153004840	05/02/17 - 05/02/17	06/05/17	0.00	2,084.00	0.00	0.00	0.00
615	5917156000458	03/10/17 - 03/10/17	06/12/17	0.00	2,481.00	0.00	0.00	0.00
615	5917156000458	03/10/17 - 03/10/17	06/12/17	0.00	2,084.00	0.00	0.00	0.00
615	5917157000023	04/27/17 - 04/27/17	06/12/17	0.00	2,481.00	0.00	0.00	0.00
615	5917157000023	04/27/17 - 04/27/17	06/12/17	0.00	2,084.00	0.00	0.00	0.00
615	2217181016031	04/13/17 - 04/13/17	07/03/17	0.00	2,481.00	0.00	0.00	0.00
615	2217181016031	04/13/17 - 04/13/17	07/03/17	0.00	2,084.00	0.00	0.00	0.00
615	5917193000653	05/31/17 - 05/31/17	07/17/17	0.00	2,481.00	0.00	0.00	0.00
615	5917193000653	05/31/17 - 05/31/17	07/17/17	0.00	2,084.00	0.00	0.00	0.00
615	5917265000100	05/30/17 - 05/30/17	09/25/17	0.00	2,481.00	0.00	0.00	0.00
615	5917265000100	05/30/17 - 05/30/17	09/25/17	0.00	2,084.00	0.00	0.00	0.00
TOTAL				0.00	41,085.00	0.00	0.00	0.00

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

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	458,670.00	ADJUSTMENTS	0.00
COVERED CHARGES	330,990.00	CONTRACTUAL ALLOW	167,363.98
NON-COVERD CHARGES	127,680.00	TOTAL MEDICAID LIAB	163,626.02
		LESS: COB	163,507.39
		LESS: COPAYMENT	118.63
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 100

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,619.00	0.00	OTHER LAB	1,927.00	0.00
MED/SURG SUPPLY	638.00	1,017.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,185.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,616.00	40,882.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,877.00	0.00	FEE SCHEDULE LAB	32,176.00	2,339.00
EKG/ECG	4,598.00	418.00	MRI SERVICES	8,030.00	9,469.00
IV THERAPY	27,275.00	146.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,105.00	22,687.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	973.00	507.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,841.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,857.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	67,504.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,923.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	61,680.00	14,295.00
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	1,891.00	71.00	TRAUMA RESPONSE	0.00	5,100.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	10,230.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,165.00	6,394.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,333.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,265.00	13,572.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,512.00	553.00			
			TOTAL ANCILLARY	330,990.00	127,680.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	330,990.00	127,680.00

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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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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,002,221.60	ADJUSTMENTS	809.10
COVERED CHARGES	953,947.60	CONTRACTUAL ALLOW	922,173.68
NON-COVERD CHARGES	48,274.00	TOTAL MEDICAID LIAB	31,773.92
		LESS: COB	0.00
		LESS: COPAYMENT	702.63
		REIMBURSEMENT	31,071.29
		TOTAL NUMBER OF CLAIMS	568

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

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,352.00	0.00	OTHER LAB	8,459.00	0.00
MED/SURG SUPPLY	551.00	99.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,652.00	1,338.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	87,009.00	25,322.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	142,863.00	1,807.00
EKG/ECG	14,630.00	0.00	MRI SERVICES	0.00	3,264.00
IV THERAPY	59,276.00	576.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,496.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,135.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,902.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	481,032.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,203.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,583.60	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	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	341.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,054.00	14,917.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	762.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,647.00	219.00			
			TOTAL ANCILLARY	953,947.60	48,274.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	953,947.60	48,274.00

Report : CLM-0810-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GWINNETT MEDICAL CENTER
1000 MEDICAL CENTER BLVD
LAWRENCEVILLE,GA 30046-7694

PROVIDER NUMBER
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,235.00	ADJUSTMENTS	0.00
COVERED CHARGES	18,301.00	CONTRACTUAL ALLOW	11,878.80
NON-COVERD CHARGES	18,934.00	TOTAL MEDICAID LIAB	6,422.20
		LESS: COB	6,410.20
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	342.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	408.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	17,133.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,138.00	326.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,254.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,790.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,843.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	526.00	1,475.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,301.00	18,934.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,301.00	18,934.00

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 07/01/16 THROUGH 06/30/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,783,709.76	ADJUSTMENTS	268,922.65
COVERED CHARGES	3,446,978.66	CONTRACTUAL ALLOW	2,691,855.13
NON-COVERD CHARGES	336,731.10	TOTAL MEDICAID LIAB	755,123.53
		LESS: COB	0.00
		LESS: COPAYMENT	582.00
		REIMBURSEMENT	754,541.53

TOTAL NUMBER OF CLAIMS 137

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 07/01/16 THROUGH 06/30/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,656.72	0.00	OTHER LAB	1,633.00	0.00
MED/SURG SUPPLY	10,349.00	11,334.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,351.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,513.00	2,242.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	468.00	FEE SCHEDULE LAB	41,411.00	4,591.00
EKG/ECG	6,270.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	180,518.00	9,857.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	308,226.50	8,356.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,875.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,608.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,530.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,948.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,298,732.44	102,717.60
RADIOLOGY THERAPEUTIC	230.00	1,134.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,758.00	105,113.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,219.00	1,094.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,964.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	285,935.00	89,824.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,251.00	0.00			
			TOTAL ANCILLARY	3,446,978.66	336,731.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,446,978.66	336,731.10

Report : CLM-0814-0
Process : CLMJ0800
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
SUMMARY TYPE VIII

Run Date: 09/05/2018
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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	07/01/16	THROUGH	06/30/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **

SUMMARY TYPE I
 INPATIENT PAID CLAIMS

PHOEBE NORTH
 2000 PALMYRA RD
 ALBANY,GA 31701-1528

PROVIDER NUMBER 000001416A
 PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,933,268.67	ADJUSTMENTS	156,829.57
COVERED CHARGES	6,590,416.69	CONTRACTUAL ALLOW	4,769,602.36
NON-COVERD CHARGES	342,851.98	TOTAL MEDICAID LIAB	1,820,814.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,820,814.33

TOTAL NUMBER OF ADMISSIONS 186

PART I - ACCOMODATIONS
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,246		0	816,130.00		238,120.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,246		0	816,130.00		238,120.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	173		0	312,011.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		37	0.00		48,470.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	173		37	312,011.00		48,470.00
TOTAL ACCOMODATIONS	1,419		37	1,128,141.00		286,590.00

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,907,377.17	0.00	OTHER LAB	25,356.00	0.00
MED/SURG SUPPLY	503,721.67	361.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	682,423.50	0.00	EDUCATION & TRAINING	77.00	0.00
RADIOLOGY-DIAGNOSTIC	114,883.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	233,226.00	3,472.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	254,688.29	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	37,932.00	0.00	MRI SERVICES	47,994.00	0.00
IV THERAPY	26,187.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	188,247.00	1,082.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	525.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416,506.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	33,220.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,007.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	325,913.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,415.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,385.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	258,503.21	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	52,797.42	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	1,152.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,138.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,722.00
OTHER IMAGING SERVICE	37,070.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,592.00	47,472.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,106.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	99,402.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,627.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,836.00	0.00			
			TOTAL ANCILLARY	5,462,275.69	56,261.98
			TOTAL ACCOMODATIONS	1,128,141.00	286,590.00
			TOTAL CHARGES	6,590,416.69	342,851.98

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 NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016320009795	11/03/16 - 11/06/16	11/21/16	0.00	2,722.00	0.00	0.00	0.00
TOTAL				0.00	2,722.00	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: 09/05/2018
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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	08/01/16	THROUGH	07/31/17
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: 09/05/2018
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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,631,855.19	ADJUSTMENTS	36,228.39
COVERED CHARGES	1,514,556.40	CONTRACTUAL ALLOW	1,200,638.45
NON-COVERD CHARGES	117,298.79	TOTAL MEDICAID LIAB	313,917.95
		LESS: COB	194.72
		LESS: COPAYMENT	396.00
		REIMBURSEMENT	313,327.23
		ALL OTHER	291,885.24
		FEE SCHEDULE-LAB	15,567.85
		INJECTABLE DRUGS	5,874.14

TOTAL NUMBER OF CLAIMS 349

SUMMARY TYPE III
 OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE NORTH
 2000 PALMYRA RD
 ALBANY,GA 31701-1528

PROVIDER NUMBER
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
 SERVICE DATES 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,623.21	493.31	OTHER LAB	4,773.00	0.00
MED/SURG SUPPLY	48,622.30	49.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	39.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,609.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	552,589.00	64,024.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	156.03	FEE SCHEDULE LAB	80,524.00	4,622.00
EKG/ECG	17,440.00	380.00	MRI SERVICES	17,044.00	0.00
IV THERAPY	34,538.00	5,011.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	69,946.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,424.00	1,283.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,373.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	313,849.00	4,204.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,706.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	200,605.40	22,204.36
RADIOLOGY THERAPEUTIC	23,923.00	3,312.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,673.00	264.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	490.00	IMPL DEV CHARGE PATIENTS	12,691.99	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,768.00	4,685.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,182.00	2,967.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,569.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,946.00	2,224.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,498.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,639.50	891.00			
			TOTAL ANCILLARY	1,514,556.40	117,298.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,514,556.40	117,298.79

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

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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 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5.52	ADJUSTMENTS	0.00
COVERED CHARGES	5.52	CONTRACTUAL ALLOW	4.18
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1.34
		LESS: COB	0.00
		LESS: COPAYMENT	1.34
		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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 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	5.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5.52	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5.52	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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PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,576.40	ADJUSTMENTS	0.00
COVERED CHARGES	43,328.73	CONTRACTUAL ALLOW	42,657.45
NON-COVERD CHARGES	2,247.67	TOTAL MEDICAID LIAB	671.28
		LESS: COB	0.00
		LESS: COPAYMENT	40.80
		REIMBURSEMENT	630.48
		TOTAL NUMBER OF CLAIMS	12

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 08/01/16 THROUGH 07/31/17
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	548.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,304.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	491.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,452.00	1,543.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,434.00	152.00
EKG/ECG	380.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,607.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,363.27	552.67
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	748.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	43,328.73	2,247.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,328.73	2,247.67

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

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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	08/01/16	THROUGH	07/31/17
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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00
SERVICE DATES 08/01/16 THROUGH 07/31/17
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,260.23	ADJUSTMENTS	5,719.18
COVERED CHARGES	31,260.23	CONTRACTUAL ALLOW	25,538.05
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,722.18
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,719.18

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE NORTH	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
2000 PALMYRA RD	000001416A	SERVICE DATES	08/01/16	THROUGH	07/31/17
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	135.26	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	488.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,652.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,824.00	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	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	421.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	520.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	545.42	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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,559.93	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,260.23	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,260.23	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

PHOEBE NORTH
2000 PALMYRA RD
ALBANY,GA 31701-1528

PROVIDER NUMBER
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/16	THROUGH	07/31/17
ADMISSION DATES	00/00/00	THROUGH	00/00/00

** NO DATA **

** END OF REPORT **