

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,155,375.60	ADJUSTMENTS	288,069.83
COVERED CHARGES	7,123,011.62	CONTRACTUAL ALLOW	4,340,728.13
NON-COVERD CHARGES	32,363.98	TOTAL MEDICAID LIAB	2,782,283.49
		LESS: COB	29,883.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,752,400.12

TOTAL NUMBER OF ADMISSIONS 420

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	940		0	480,340.00		1,652.00
ROUTINE NURSERY	158		0	72,888.00		354.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,098		0	553,228.00		2,006.00
SPECIAL CARE SERVICES						
CCU	198		0	218,861.00		0.00
ICU	18		0	11,934.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	2		0	1,326.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	218		0	232,121.00		0.00
TOTAL ACCOMODATIONS	1,316		0	785,349.00		2,006.00

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 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,457,363.56	1,232.11	OTHER LAB	17,778.55	0.00
MED/SURG SUPPLY	828,334.86	7,400.81	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	893,642.33	424.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,331.95	0.00	OTHER THERAPEUTIC SVC	1,045.55	1,167.93
CT SCAN	198,523.46	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,050.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	35,671.80	0.00	MRI SERVICES	34,163.85	0.00
IV THERAPY	82,039.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	619,537.61	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	96,465.28	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	326,312.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	125,036.16	1,364.90	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	260,359.17	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	69,484.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	796.46
LABORATORY PATHOLOGIC	35,561.15	0.00	INJECTABLE DRUGS	418,293.20	9,209.56
RADIOLOGY THERAPEUTIC	458.81	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,658.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,703.20	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	219.11	2,790.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	362,370.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,123.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	64,748.23	1,381.53			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,257.50	4,590.51			
AUDIOLOGY	5,914.80	0.00			
CARDIOLOGY	81,629.98	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,674.14	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	48,909.61	0.00			
			TOTAL ANCILLARY	6,337,662.62	30,357.98
			TOTAL ACCOMODATIONS	785,349.00	2,006.00
			TOTAL CHARGES	7,123,011.62	32,363.98

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	08/01/11	THROUGH	07/31/12
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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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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,555,071.92	ADJUSTMENTS	206,295.27
COVERED CHARGES	5,951,915.26	CONTRACTUAL ALLOW	4,266,734.12
NON-COVERD CHARGES	603,156.66	TOTAL MEDICAID LIAB	1,685,181.14
		LESS: COB	700.39
		LESS: COPAYMENT	6,141.83
		REIMBURSEMENT	1,678,338.92
		ALL OTHER	1,363,348.32
		FEE SCHEDULE-LAB	185,634.41
		INJECTABLE DRUGS	129,356.19

TOTAL NUMBER OF CLAIMS 4,849

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

PROVIDER NUMBER  
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PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	489,734.76	19,612.30	OTHER LAB	38,412.99	0.00
MED/SURG SUPPLY	409,238.14	7,170.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	168.90	EDUCATION & TRAINING	0.00	116.40
RADIOLOGY-DIAGNOSTIC	307,061.66	14,347.64	OTHER THERAPEUTIC SVC	209.11	9,119.74
CT SCAN	535,529.55	66,528.45	SPECIAL CHARGES	68.27	0.00
PHYSICAL THERAPY	60,508.48	26,836.34	FEE SCHEDULE LAB	813,549.76	119,428.20
EKG/ECG	64,110.64	5,525.26	MRI SERVICES	206,471.45	22,288.58
IV THERAPY	260,690.58	30,851.89	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	612,371.35	85,095.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,417.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,633.80	10,242.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	119,758.72	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	824,844.62	25,063.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,190.48	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,992.38
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	487,460.21	93,302.97
RADIOLOGY THERAPEUTIC	57,179.09	157.31	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,601.07	7,573.30	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,119.73	1,565.84	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	8.60
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	98,073.83	12,018.06	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	80.96	0.00	IMPL DEV CHARGE PATIENTS	58,533.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7.95
OTHER IMAGING SERVICE	171,554.44	12,511.98			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,390.57	4,049.78			
ONCOLOGY	1,753.04	0.00			
NUCLEAR MEDICINE	54,788.48	16,019.05			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	61,261.42	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,978.74	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,338.05	2,638.98			
			TOTAL ANCILLARY	5,951,915.26	594,242.13
			TOTAL ACCOMODATIONS	0.00	8,914.53
			TOTAL CHARGES	5,951,915.26	603,156.66

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

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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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1111290006486	09/09/11 - 09/09/11	11/07/11	0.00	7.95	0.00	0.00	0.00
TOTAL				0.00	7.95	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

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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,848.75	ADJUSTMENTS	0.00
COVERED CHARGES	16,917.36	CONTRACTUAL ALLOW	16,178.15
NON-COVERD CHARGES	1,931.39	TOTAL MEDICAID LIAB	739.21
		LESS: COB	727.21
		LESS: COPAYMENT	12.00
		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

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

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PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,590.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	723.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	724.34	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,090.26	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,523.19	60.96
EKG/ECG	380.44	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,548.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,602.36	209.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	392.11	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	342.68	1,661.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,917.36	1,931.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,917.36	1,931.39



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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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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	434,236.23	ADJUSTMENTS	1,226.63
COVERED CHARGES	422,282.95	CONTRACTUAL ALLOW	386,870.36
NON-COVERD CHARGES	11,953.28	TOTAL MEDICAID LIAB	35,412.59
		LESS: COB	14.13
		LESS: COPAYMENT	1,437.02
		REIMBURSEMENT	33,961.44
		TOTAL NUMBER OF CLAIMS	639

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,035.83	936.68	OTHER LAB	4,092.92	0.00
MED/SURG SUPPLY	21,073.27	351.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,433.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,548.05
CT SCAN	32,927.81	1,249.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,251.95	1,773.92
EKG/ECG	4,565.28	0.00	MRI SERVICES	6,626.71	0.00
IV THERAPY	15,718.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,140.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	739.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,923.28	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	193,257.24	2,829.05	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,092.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,726.66	1,230.33
RADIOLOGY THERAPEUTIC	458.81	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	691.72	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,354.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,663.74	1,839.48			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	510.72	0.00			
			TOTAL ANCILLARY	422,282.95	11,758.28
			TOTAL ACCOMODATIONS	0.00	195.00
			TOTAL CHARGES	422,282.95	11,953.28

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: 09/24/2013  
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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	08/01/11	THROUGH	07/31/12
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: 09/24/2013  
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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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	753,961.27	ADJUSTMENTS	21,141.84
COVERED CHARGES	712,188.67	CONTRACTUAL ALLOW	553,377.37
NON-COVERD CHARGES	41,772.60	TOTAL MEDICAID LIAB	158,811.30
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	158,619.30

TOTAL NUMBER OF CLAIMS 30

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

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

Run Date: 09/24/2013  
 Run Time: 13:55:08  
 Page: 13

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,959.58	67.13	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,923.17	210.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	848.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,042.57	1,421.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	273.57	FEE SCHEDULE LAB	9,577.52	1,622.96
EKG/ECG	0.00	0.00	MRI SERVICES	3,156.36	0.00
IV THERAPY	6,779.44	3,554.87	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,659.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	247.36	647.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,223.23	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,892.37	209.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,820.18	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	503,291.38	33,596.03
RADIOLOGY THERAPEUTIC	35,741.69	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	169.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,651.92	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,324.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	818.89	0.00			
ONCOLOGY	219.13	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,010.88	0.00			
			TOTAL ANCILLARY	712,188.67	41,772.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	712,188.67	41,772.60

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: 09/24/2013  
Run Time: 13:55:10  
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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	08/01/11	THROUGH	07/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

PROVIDER NUMBER 000000052A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,890,812.79	ADJUSTMENTS	68,883.90
COVERED CHARGES	2,838,207.79	CONTRACTUAL ALLOW	1,511,755.95
NON-COVERD CHARGES	52,605.00	TOTAL MEDICAID LIAB	1,326,451.84
		LESS: COB	901.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,325,549.86

TOTAL NUMBER OF ADMISSIONS 279

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	835		0	404,985.00		36,587.00
ROUTINE NURSERY	126		0	29,859.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	961		0	434,844.00		36,587.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	67		0	70,544.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		6	0.00		2,748.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	67		6	70,544.00		2,748.00
TOTAL ACCOMODATIONS	1,028		6	505,388.00		39,335.00

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233,260.89	0.00	OTHER LAB	7,577.00	0.00
MED/SURG SUPPLY	160,730.33	33.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	438,049.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,177.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	106,046.00	404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,317.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	27,620.00	0.00	MRI SERVICES	24,708.00	0.00
IV THERAPY	170,993.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,080.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	145,011.00	226.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	145,712.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,372.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,380.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,421.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,913.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	479,552.88	0.00
RADIOLOGY THERAPEUTIC	785.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	321.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,539.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,777.00	2,752.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	49,414.00	9,855.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,868.00	0.00			
AUDIOLOGY	3,430.00	0.00			
CARDIOLOGY	18,872.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,090.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,803.00	0.00			
			TOTAL ANCILLARY	2,332,819.79	13,270.00
			TOTAL ACCOMODATIONS	505,388.00	39,335.00
			TOTAL CHARGES	2,838,207.79	52,605.00



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

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
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: 09/24/2013  
Run Time: 13:55:40  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,909,316.78	ADJUSTMENTS	95,713.79
COVERED CHARGES	2,550,373.28	CONTRACTUAL ALLOW	2,031,729.30
NON-COVERD CHARGES	358,943.50	TOTAL MEDICAID LIAB	518,643.98
		LESS: COB	23.00
		LESS: COPAYMENT	2,256.00
		REIMBURSEMENT	516,364.98
		ALL OTHER	402,292.85
		FEE SCHEDULE-LAB	74,805.89
		INJECTABLE DRUGS	39,266.24
		TOTAL NUMBER OF CLAIMS	2,468

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

PROVIDER NUMBER  
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,998.95	8,227.02	OTHER LAB	15,671.00	2,140.00
MED/SURG SUPPLY	91,637.21	3,656.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	134,515.00	3,912.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	205,505.00	11,861.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,454.00	4,519.00	FEE SCHEDULE LAB	684,806.00	165,225.20
EKG/ECG	38,070.00	2,275.00	MRI SERVICES	135,994.00	12,528.00
IV THERAPY	190,013.00	12,840.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,962.00	13,937.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,385.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,534.00	4,857.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,715.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	28,835.00	6,205.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	288,429.20	3,774.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,278.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	202,932.92	84,213.02
RADIOLOGY THERAPEUTIC	12,705.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	86.00	811.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,259.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,018.00	274.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16.00	3,193.49
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18.00
OTHER IMAGING SERVICE	63,111.00	1,672.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,340.00	8,541.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,179.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,572.00	77.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,794.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,558.00	4,186.00			
			TOTAL ANCILLARY	2,550,373.28	358,943.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,550,373.28	358,943.50

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: 09/24/2013  
Run Time: 13:55:40  
Page: 6

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9712213957033	03/29/12 - 03/30/12	08/06/12	0.00	18.00	0.00	0.00	0.00
TOTAL				0.00	18.00	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: 09/24/2013  
Run Time: 13:56:46  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,027.59	ADJUSTMENTS	0.00
COVERED CHARGES	26,887.78	CONTRACTUAL ALLOW	14,150.66
NON-COVERD CHARGES	6,139.81	TOTAL MEDICAID LIAB	12,737.12
		LESS: COB	12,695.12
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

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

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

PROVIDER NUMBER  
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	859.88	0.00	OTHER LAB	419.00	535.00
MED/SURG SUPPLY	278.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,109.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,609.00	2,422.00
EKG/ECG	830.00	70.00	MRI SERVICES	1,901.00	0.00
IV THERAPY	802.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	704.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,968.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	241.75	360.81
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	363.00	2,752.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,083.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	637.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,002.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	81.00	0.00			
			TOTAL ANCILLARY	26,887.78	6,139.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,887.78	6,139.81

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

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

Run Date: 09/24/2013  
Run Time: 13:56:48  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,570.90	ADJUSTMENTS	541.40
COVERED CHARGES	79,453.99	CONTRACTUAL ALLOW	71,535.45
NON-COVERD CHARGES	2,116.91	TOTAL MEDICAID LIAB	7,918.54
		LESS: COB	0.00
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	7,675.54
		TOTAL NUMBER OF CLAIMS	142

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

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

Run Date: 09/24/2013  
 Run Time: 13:56:48  
 Page: 10

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,258.76	20.00	OTHER LAB	279.00	0.00
MED/SURG SUPPLY	1,018.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,362.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,603.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,859.00	1,086.00
EKG/ECG	620.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,774.00	120.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,542.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	606.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,101.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,750.60	641.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	283.00	249.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,397.00	0.00			
			TOTAL ANCILLARY	79,453.99	2,116.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,453.99	2,116.91



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

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

Run Date: 09/24/2013  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,219.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,203.00	CONTRACTUAL ALLOW	807.67
NON-COVERD CHARGES	16.00	TOTAL MEDICAID LIAB	395.33
		LESS: COB	392.33
		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: 09/24/2013  
 Run Time: 13:56:52  
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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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 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	879.00	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	324.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,203.00	16.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,203.00	16.00

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: 09/24/2013  
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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	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
Run Time: 13:56:53  
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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	09/01/11	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

JOHN D ARCHBOLD MEMORIAL HOSPITAL  
 915 GORDON AVE  
 THOMASVILLE,GA 31792-6614

PROVIDER NUMBER 000000063A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,502,347.33	ADJUSTMENTS	1,387,925.87
COVERED CHARGES	27,206,999.33	CONTRACTUAL ALLOW	17,995,617.53
NON-COVERD CHARGES	295,348.00	TOTAL MEDICAID LIAB	9,211,381.80
		LESS: COB	38,896.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,172,485.36
		TOTAL NUMBER OF ADMISSIONS	1,041

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,522		0	3,830,163.00		19,100.00
ROUTINE NURSERY	121		0	57,157.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,643		0	3,887,320.00		19,100.00
SPECIAL CARE SERVICES						
CCU	108		0	140,076.00		0.00
ICU	1,128		0	1,337,428.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		260	0.00		189,710.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,236		260	1,477,504.00		189,710.00
TOTAL ACCOMODATIONS	6,879		260	5,364,824.00		208,810.00

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

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

Run Date: 09/24/2013  
 Run Time: 13:57:00  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,189,567.96	87.00	OTHER LAB	53,149.00	0.00
MED/SURG SUPPLY	2,140,627.00	13,753.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,885,631.81	3,420.00	EDUCATION & TRAINING	239.00	0.00
RADIOLOGY-DIAGNOSTIC	507,405.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,097,957.00	11,161.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	291,975.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	72,128.00	0.00	MRI SERVICES	280,578.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,722,455.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	99,367.00	176.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	937,866.00	2,714.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	122,804.00	281.00	AMBULANCE	0.00	0.00
GI SERVICES	111,157.00	1,100.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	665,322.00	8,643.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	155,202.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	121,770.26	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	166,757.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	140,461.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	74,223.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	232,860.00	12,262.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34.00	8,041.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	824.00	IMPL DEV CHARGE PATIENTS	1,720,289.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	78,948.00	19,908.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	299,158.30	4,104.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,728.00	0.00			
AUDIOLOGY	6,171.00	0.00			
CARDIOLOGY	537,760.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,112.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,473.00	64.00			
			TOTAL ANCILLARY	21,842,175.33	86,538.00
			TOTAL ACCOMODATIONS	5,364,824.00	208,810.00
			TOTAL CHARGES	27,206,999.33	295,348.00

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

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

Run Date: 09/24/2013  
 Run Time: 13:57:47  
 Page: 3

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	134,443.00	ADJUSTMENTS	0.00
COVERED CHARGES	134,443.00	CONTRACTUAL ALLOW	13,771.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	120,671.13
		LESS: COB	120,671.13
		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	16		0	8,816.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	16		0	8,816.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	13		0	13,780.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	13,780.00		0.00
TOTAL ACCOMODATIONS	29		0	22,596.00		0.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,338.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,986.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,658.00	0.00	EDUCATION & TRAINING	133.00	0.00
RADIOLOGY-DIAGNOSTIC	2,007.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,432.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,414.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,983.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,524.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,534.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	644.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,438.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	996.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,635.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	125.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	111,847.00	0.00
			TOTAL ACCOMODATIONS	22,596.00	0.00
			TOTAL CHARGES	134,443.00	0.00



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

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

Run Date: 09/24/2013  
Run Time: 13:57:49  
Page: 5

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,119,809.33	ADJUSTMENTS	731,074.91
COVERED CHARGES	15,443,735.74	CONTRACTUAL ALLOW	11,783,563.26
NON-COVERD CHARGES	1,676,073.59	TOTAL MEDICAID LIAB	3,660,172.48
		LESS: COB	485.26
		LESS: COPAYMENT	17,097.66
		REIMBURSEMENT	3,642,589.56
		ALL OTHER	2,512,748.62
		FEE SCHEDULE-LAB	277,929.37
		INJECTABLE DRUGS	851,911.57

TOTAL NUMBER OF CLAIMS 9,338

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

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

Run Date: 09/24/2013  
 Run Time: 13:57:49  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328,922.00	59,426.00	OTHER LAB	57,402.00	2,176.00
MED/SURG SUPPLY	774,257.00	2,062.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,581.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	459,095.00	22,216.00	OTHER THERAPEUTIC SVC	0.00	220.00
CT SCAN	1,408,136.00	169,106.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,510.00	19,895.00	FEE SCHEDULE LAB	1,913,238.18	319,277.54
EKG/ECG	67,943.00	3,549.00	MRI SERVICES	435,802.00	29,068.00
IV THERAPY	480,570.00	86,792.00	PROFESSIONAL FEES	0.00	14.00
OPERATING ROOM	1,126,412.85	156,520.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,241.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,075.00	52,076.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	83,710.00	14,683.00	AMBULANCE	0.00	0.00
GI SERVICES	239,319.18	39,455.82	CAST ROOM	0.00	0.00
EMERGENCY ROOM	808,468.00	2,600.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	174,936.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,800.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,167,232.53	478,751.08
RADIOLOGY THERAPEUTIC	1,438,014.00	107,825.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,108.00	10,390.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,655.00	1,874.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	161,724.00	10,567.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	32,460.00	0.00	IMPL DEV CHARGE PATIENTS	113,020.00	364.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	344,525.00	27,918.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	55,465.00	23,646.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	197,740.00	1,002.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	221,595.00	11,863.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	123,147.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	110,013.00	14,356.00			
			TOTAL ANCILLARY	15,443,735.74	1,676,073.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,443,735.74	1,676,073.59

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

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

Run Date: 09/24/2013  
Run Time: 14:00:49  
Page: 7

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,196.30	ADJUSTMENTS	0.00
COVERED CHARGES	38,759.00	CONTRACTUAL ALLOW	3,647.07
NON-COVERD CHARGES	22,437.30	TOTAL MEDICAID LIAB	35,111.93
		LESS: COB	35,070.53
		LESS: COPAYMENT	41.40
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,743.00	86.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,055.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	189.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,466.00	4,513.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,504.00	1,011.30
EKG/ECG	142.00	0.00	MRI SERVICES	2,955.00	5,777.00
IV THERAPY	1,823.00	139.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,123.00	9,588.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,173.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50.00	188.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,004.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,779.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,490.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,126.00	495.00
RADIOLOGY THERAPEUTIC	1,440.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,035.00	324.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	662.00	316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,759.00	22,437.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,759.00	22,437.30

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

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

Run Date: 09/24/2013  
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Page: 9

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	291,325.00	ADJUSTMENTS	2,955.76
COVERED CHARGES	266,277.00	CONTRACTUAL ALLOW	245,390.11
NON-COVERD CHARGES	25,048.00	TOTAL MEDICAID LIAB	20,886.89
		LESS: COB	0.00
		LESS: COPAYMENT	783.03
		REIMBURSEMENT	20,103.86
		TOTAL NUMBER OF CLAIMS	374

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,096.00	1,095.00	OTHER LAB	295.00	0.00
MED/SURG SUPPLY	8,422.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,142.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,337.00	8,616.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	212.00	FEE SCHEDULE LAB	55,541.00	5,480.00
EKG/ECG	2,008.00	142.00	MRI SERVICES	3,874.00	2,509.00
IV THERAPY	24,132.00	3,625.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,358.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,352.00	802.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	117,907.00	35.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,074.00	2,216.00
RADIOLOGY THERAPEUTIC	953.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	374.00	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	2,191.00	316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	266,277.00	25,048.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	266,277.00	25,048.00

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: 09/24/2013  
Run Time: 14:01:03  
Page: 11

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,270.00	ADJUSTMENTS	0.00
COVERED CHARGES	954.00	CONTRACTUAL ALLOW	363.45
NON-COVERD CHARGES	316.00	TOTAL MEDICAID LIAB	590.55
		LESS: COB	590.55
		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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	514.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	90.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	954.00	316.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	954.00	316.00



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

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

Run Date: 09/24/2013  
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Page: 13

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,010,757.54	ADJUSTMENTS	190,647.41
COVERED CHARGES	2,716,846.17	CONTRACTUAL ALLOW	2,273,350.19
NON-COVERD CHARGES	293,911.37	TOTAL MEDICAID LIAB	443,495.98
		LESS: COB	0.00
		LESS: COPAYMENT	417.00
		REIMBURSEMENT	443,078.98
		TOTAL NUMBER OF CLAIMS	86

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,606.00	4,963.00	OTHER LAB	1,682.00	0.00
MED/SURG SUPPLY	242,658.00	154.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,334.00	20,316.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,719.00	3,493.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	599.00	FEE SCHEDULE LAB	43,641.37	3,775.50
EKG/ECG	2,398.00	109.00	MRI SERVICES	0.00	8,885.00
IV THERAPY	31,501.00	8,771.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	318,239.47	72,748.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	308.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,298.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	629.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,625.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,003,052.33	151,631.34
RADIOLOGY THERAPEUTIC	343,491.00	2,742.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,680.00	136.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	484,475.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	242.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,692.00	1,026.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,344.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	90,925.00	12,900.00			
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	3,306.00	1,662.00			
			TOTAL ANCILLARY	2,716,846.17	293,911.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,716,846.17	293,911.37

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

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

Run Date: 09/24/2013  
Run Time: 14:01:11  
Page: 15

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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000074A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,505,086.14	ADJUSTMENTS	2,452,828.03
COVERED CHARGES	61,397,569.07	CONTRACTUAL ALLOW	44,024,088.72
NON-COVERD CHARGES	1,107,517.07	TOTAL MEDICAID LIAB	17,373,480.35
		LESS: COB	162,636.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,210,843.42

TOTAL NUMBER OF ADMISSIONS 2,186

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,307		12	5,601,839.00		373,907.00
ROUTINE NURSERY	1,416		8	1,497,707.00		329,509.00
SWING BED	0		192	0.00		1,632.79
LEAVE OF ABSENCE	0		0	0.00		40.00
TOTAL ROUTINE	8,723		212	7,099,546.00		705,088.79
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	962		0	1,918,985.00		3,998.00
NICU	305		0	794,831.50		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	1,267		0	2,713,816.50		3,998.00
TOTAL ACCOMODATIONS	9,990		212	9,813,362.50		709,086.79

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,407,497.68	61,208.43	OTHER LAB	397,696.00	1,769.00
MED/SURG SUPPLY	3,967,975.91	109,074.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,443,780.60	28,149.16	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,156,604.40	3,414.00	OTHER THERAPEUTIC SVC	0.00	17,106.00
CT SCAN	2,551,301.00	14,138.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	204,337.00	5,116.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,567,157.00	698.00	MRI SERVICES	810,992.00	2,585.00
IV THERAPY	35,159.00	289.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,046,823.96	31,099.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,478,556.00	2,165.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,303,630.93	17,815.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	169,471.74	469.10	AMBULANCE	0.00	0.00
GI SERVICES	527,943.15	2,435.42	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,401,424.51	2,276.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	638,029.00	1,661.30	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	513,066.09	564.00	INJECTABLE DRUGS	1,720,715.89	10,865.55
RADIOLOGY THERAPEUTIC	287,392.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	114,051.00	4,205.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	88,149.00	1,238.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,585.00	TRAUMA RESPONSE	0.00	50,512.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,292,166.23	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	388,636.00	16,782.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	650,291.00	5,008.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	276,710.00	994.00			
AUDIOLOGY	40,716.00	0.00			
CARDIOLOGY	1,523,073.50	1,636.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	179,159.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	401,700.98	1,572.00			
			TOTAL ANCILLARY	51,584,206.57	398,430.28
			TOTAL ACCOMODATIONS	9,813,362.50	709,086.79
			TOTAL CHARGES	61,397,569.07	1,107,517.07

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	445,274.84	ADJUSTMENTS	0.00
COVERED CHARGES	438,687.84	CONTRACTUAL ALLOW	210,823.18
NON-COVERD CHARGES	6,587.00	TOTAL MEDICAID LIAB	227,864.66
		LESS: COB	227,864.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 32

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	84		0	58,626.00		5,160.00
ROUTINE NURSERY	11		0	8,669.00		1,110.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	95		0	67,295.00		6,270.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	3,998.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	3,998.00		0.00
TOTAL ACCOMODATIONS	97		0	71,293.00		6,270.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,445.03	0.00	OTHER LAB	4,651.00	0.00
MED/SURG SUPPLY	26,803.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,327.15	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,343.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,124.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,343.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,418.00	0.00	MRI SERVICES	9,333.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,595.54	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	102,221.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,762.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,084.79	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,341.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,693.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,546.12	0.00	INJECTABLE DRUGS	15,256.94	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,046.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	317.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	348.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,823.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,502.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	468.00	0.00			
CARDIOLOGY	1,636.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,283.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	367,394.84	317.00
			TOTAL ACCOMODATIONS	71,293.00	6,270.00
			TOTAL CHARGES	438,687.84	6,587.00

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: 09/24/2013  
Run Time: 14:03:39  
Page: 5

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,357,823.37	ADJUSTMENTS	1,755,902.15
COVERED CHARGES	29,991,536.54	CONTRACTUAL ALLOW	23,798,567.16
NON-COVERD CHARGES	2,366,286.83	TOTAL MEDICAID LIAB	6,192,969.38
		LESS: COB	18,388.62
		LESS: COPAYMENT	19,176.30
		REIMBURSEMENT	6,155,404.46
		ALL OTHER	5,222,949.71
		FEE SCHEDULE-LAB	714,137.79
		INJECTABLE DRUGS	218,316.96

TOTAL NUMBER OF CLAIMS 13,849



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

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

Run Date: 09/24/2013  
 Run Time: 14:03:39  
 Page: 6

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	877,295.89	789.67	OTHER LAB	408,814.00	0.00
MED/SURG SUPPLY	1,053,454.84	301.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	84,153.71	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,171,014.28	20,612.00	OTHER THERAPEUTIC SVC	0.00	1,376.00
CT SCAN	3,254,693.00	123,085.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,118.00	31,660.00	FEE SCHEDULE LAB	5,074,545.62	1,134,220.34
EKG/ECG	630,104.00	4,448.00	MRI SERVICES	1,091,894.00	36,226.00
IV THERAPY	726,583.00	335.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,050,166.92	202,181.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	167,364.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	246,474.00	21,226.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	114,474.65	209.44	AMBULANCE	0.00	0.00
GI SERVICES	521,398.94	13,738.33	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,256,342.34	17,647.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	509,123.07	752.01	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,410,516.15	390,841.57
RADIOLOGY THERAPEUTIC	275,127.00	1,544.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,321.00	11,903.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,843.00	7,739.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	128,288.00	2,587.00	TRAUMA RESPONSE	0.00	9,184.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	320,903.66	13,075.85
LITHOTRIPSY	31,590.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	741,774.67	22,776.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	126,252.00	3,925.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,616,321.00	35,862.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,064,171.58	155,876.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	435,311.00	5,622.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	579,256.93	12,390.00			
			TOTAL ANCILLARY	29,991,536.54	2,366,286.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,991,536.54	2,366,286.83

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

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

Run Date: 09/24/2013  
Run Time: 14:08:33  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	637,880.50	ADJUSTMENTS	0.00
COVERED CHARGES	562,324.44	CONTRACTUAL ALLOW	313,910.04
NON-COVERD CHARGES	75,556.06	TOTAL MEDICAID LIAB	248,414.40
		LESS: COB	248,281.63
		LESS: COPAYMENT	132.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 208

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

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,643.78	0.00	OTHER LAB	4,586.00	1,590.00
MED/SURG SUPPLY	31,328.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,887.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,391.00	3,822.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	332.00	1,283.00	FEE SCHEDULE LAB	92,942.02	12,173.92
EKG/ECG	7,476.00	0.00	MRI SERVICES	2,655.00	0.00
IV THERAPY	16,196.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	140,054.27	26,289.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,690.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,379.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,054.32	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,702.13	4,870.84	CAST ROOM	0.00	0.00
EMERGENCY ROOM	92,066.00	358.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,763.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,428.96	11,092.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	332.00	1,684.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,466.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	820.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	737.57	4,476.63
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,755.00	1,288.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,850.00	5,161.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,355.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,272.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,341.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,287.06	0.00			
			TOTAL ANCILLARY	562,324.44	75,556.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	562,324.44	75,556.06

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

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

Run Date: 09/24/2013  
Run Time: 14:08:40  
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ATHENS REGIONAL MEDICAL CTR  
1199 PRINCE AVE  
ATHENS,GA 30606-2797

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,078,281.74	ADJUSTMENTS	3,850.57
COVERED CHARGES	1,043,019.32	CONTRACTUAL ALLOW	999,106.44
NON-COVERD CHARGES	35,262.42	TOTAL MEDICAID LIAB	43,912.88
		LESS: COB	0.00
		LESS: COPAYMENT	1,476.16
		REIMBURSEMENT	42,436.72
		TOTAL NUMBER OF CLAIMS	785

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,457.13	0.00	OTHER LAB	5,457.00	1,590.00
MED/SURG SUPPLY	15,124.08	161.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,397.00	202.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,239.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	212.00	0.00	FEE SCHEDULE LAB	216,632.08	20,709.78
EKG/ECG	10,008.00	0.00	MRI SERVICES	2,585.00	0.00
IV THERAPY	24,559.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,405.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,670.00	737.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	880.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,070.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	570,763.00	336.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,510.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,361.86	9,847.80
RADIOLOGY THERAPEUTIC	7,083.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	501.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,478.85	322.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,300.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,283.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,042.00	1,356.00			
			TOTAL ANCILLARY	1,043,019.32	35,262.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,043,019.32	35,262.42

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: 09/24/2013  
Run Time: 14:08:53  
Page: 11

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,027.92	ADJUSTMENTS	0.00
COVERED CHARGES	48,895.94	CONTRACTUAL ALLOW	24,777.53
NON-COVERD CHARGES	14,131.98	TOTAL MEDICAID LIAB	24,118.41
		LESS: COB	24,088.39
		LESS: COPAYMENT	30.02
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	21

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

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

Run Date: 09/24/2013  
 Run Time: 14:08:53  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,093.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,476.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,822.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,581.25	1,170.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,237.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	11,891.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	322.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	345.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,150.00	177.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,339.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,774.68	893.01
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	59.37	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,560.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	829.00	0.00			
			TOTAL ANCILLARY	48,895.94	14,131.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,895.94	14,131.98

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: 09/24/2013  
Run Time: 14:08:57  
Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,305,553.11	ADJUSTMENTS	344,278.95
COVERED CHARGES	3,964,936.88	CONTRACTUAL ALLOW	3,360,244.58
NON-COVERD CHARGES	340,616.23	TOTAL MEDICAID LIAB	604,692.30
		LESS: COB	8,003.41
		LESS: COPAYMENT	1,731.00
		REIMBURSEMENT	594,957.89
		TOTAL NUMBER OF CLAIMS	115



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

ATHENS REGIONAL MEDICAL CTR	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1199 PRINCE AVE	000000074A	SERVICE DATES	10/01/11	THROUGH	09/30/12
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	81,786.56	49.20	OTHER LAB	5,908.00	0.00
MED/SURG SUPPLY	169,178.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,124.00	5,715.00	OTHER THERAPEUTIC SVC	0.00	6,880.00
CT SCAN	318,134.00	3,120.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	424.00	FEE SCHEDULE LAB	135,064.81	62,724.23
EKG/ECG	57,880.00	0.00	MRI SERVICES	6,200.00	0.00
IV THERAPY	40,288.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	459,065.57	16,341.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,560.00	605.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,253.01	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,236.00	266.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,372.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	627,511.58	121,142.86
RADIOLOGY THERAPEUTIC	881,877.00	73,538.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	24,229.00	1,932.00	TRAUMA RESPONSE	0.00	4,592.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	603,060.14	6,133.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,139.00	577.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,086.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	67,687.00	1,659.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	285,487.00	34,917.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,809.40	0.00			
			TOTAL ANCILLARY	3,964,936.88	340,616.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,964,936.88	340,616.23

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: 09/24/2013  
Run Time: 14:09:04  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:09:14  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,481,999.94	ADJUSTMENTS	3,774.11
COVERED CHARGES	1,426,223.57	CONTRACTUAL ALLOW	972,284.43
NON-COVERD CHARGES	55,776.37	TOTAL MEDICAID LIAB	453,939.14
		LESS: COB	4,696.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	449,242.99

TOTAL NUMBER OF ADMISSIONS 91

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	246		0	148,505.00		3,150.00
ROUTINE NURSERY	12		0	6,999.00		608.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	258		0	155,504.00		3,758.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	42		0	46,446.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	42		0	46,446.00		0.00
TOTAL ACCOMODATIONS	300		0	201,950.00		3,758.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	241,260.67	0.00	OTHER LAB	5,238.20	0.00
MED/SURG SUPPLY	184,033.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	209,435.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,948.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,295.40	24,022.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,138.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	17,733.20	0.00	MRI SERVICES	26,795.80	0.00
IV THERAPY	2,787.00	24,630.77	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	119,273.30	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,537.80	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,507.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,040.54	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,408.80	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,577.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,982.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	491.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,806.50	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	153,106.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,677.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,882.60	2,874.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,179.60	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	2,627.00	0.00			
			TOTAL ANCILLARY	1,224,273.57	52,018.37
			TOTAL ACCOMODATIONS	201,950.00	3,758.00
			TOTAL CHARGES	1,426,223.57	55,776.37

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: 09/24/2013  
 Run Time: 14:09:27  
 Page: 3

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,303.40	ADJUSTMENTS	0.00
COVERED CHARGES	5,403.80	CONTRACTUAL ALLOW	3,835.80
NON-COVERD CHARGES	899.60	TOTAL MEDICAID LIAB	1,568.00
		LESS: COB	1,568.00
		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	0		0	0.00		0.00
ROUTINE NURSERY	2		0	1,208.00		776.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,208.00		776.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,208.00		776.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,693.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	916.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,110.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	476.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	123.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	4,195.80	123.60
			TOTAL ACCOMODATIONS	1,208.00	776.00
			TOTAL CHARGES	5,403.80	899.60

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,346,033.30	ADJUSTMENTS	21,202.95
COVERED CHARGES	1,125,919.69	CONTRACTUAL ALLOW	818,382.49
NON-COVERD CHARGES	220,113.61	TOTAL MEDICAID LIAB	307,537.20
		LESS: COB	156.32
		LESS: COPAYMENT	1,308.00
		REIMBURSEMENT	306,072.88
		ALL OTHER	275,361.54
		FEE SCHEDULE-LAB	30,711.34
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,188

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,087.43	5,425.78	OTHER LAB	8,018.50	0.00
MED/SURG SUPPLY	78,676.86	267.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	152.80	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	96,491.30	957.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,046.80	58,614.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	971.30	1,244.70	FEE SCHEDULE LAB	336,458.90	83,463.20
EKG/ECG	24,787.30	327.20	MRI SERVICES	69,543.60	5,408.70
IV THERAPY	2,188.80	16,753.23	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	53,100.70	29,250.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,436.30	70.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,013.20	5,576.00	AMBULANCE	0.00	0.00
GI SERVICES	25,695.20	1,359.90	CAST ROOM	0.00	0.00
EMERGENCY ROOM	198,159.20	2,425.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,982.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	814.30	3,628.90	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,209.60	334.40	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,209.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,098.70	3,190.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,711.40	717.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,324.90	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,025.80	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,868.00	0.00			
			TOTAL ANCILLARY	1,125,919.69	219,168.61
			TOTAL ACCOMODATIONS	0.00	945.00
			TOTAL CHARGES	1,125,919.69	220,113.61



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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,353.50	ADJUSTMENTS	0.00
COVERED CHARGES	2,181.00	CONTRACTUAL ALLOW	1,370.81
NON-COVERD CHARGES	2,172.50	TOTAL MEDICAID LIAB	810.19
		LESS: COB	804.94
		LESS: COPAYMENT	5.25
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.40	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	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,174.60	2,172.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,181.00	2,172.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,181.00	2,172.50

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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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	172,496.43	ADJUSTMENTS	144.00
COVERED CHARGES	156,324.23	CONTRACTUAL ALLOW	142,474.23
NON-COVERD CHARGES	16,172.20	TOTAL MEDICAID LIAB	13,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	516.00
		REIMBURSEMENT	13,334.00
		TOTAL NUMBER OF CLAIMS	277

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,800.53	170.10	OTHER LAB	1,440.50	0.00
MED/SURG SUPPLY	1,699.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,666.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,625.40	9,323.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,116.20	5,446.80
EKG/ECG	1,513.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	500.10	1,101.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	659.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,528.10	90.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	463.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	312.00	0.00			
			TOTAL ANCILLARY	156,324.23	16,132.90
			TOTAL ACCOMODATIONS	0.00	39.30
			TOTAL CHARGES	156,324.23	16,172.20

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,468.90	ADJUSTMENTS	0.00
COVERED CHARGES	1,368.80	CONTRACTUAL ALLOW	1,154.30
NON-COVERD CHARGES	100.10	TOTAL MEDICAID LIAB	214.50
		LESS: COB	214.50
		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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56.30	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	100.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	658.50	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	549.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,368.80	100.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,368.80	100.10

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	146,853.42	ADJUSTMENTS	4,473.69
COVERED CHARGES	142,832.72	CONTRACTUAL ALLOW	138,356.03
NON-COVERD CHARGES	4,020.70	TOTAL MEDICAID LIAB	4,476.69
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,473.69

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: 09/24/2013  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
 000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,741.70	90.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,725.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	110.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,820.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	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	366.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	142,832.72	4,020.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	142,832.72	4,020.70



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

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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

OCONEE REGIONAL MEDICAL CENTER  
 821 N COBB ST  
 MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER 000000129A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,841,504.55	ADJUSTMENTS	177,792.25
COVERED CHARGES	6,779,870.51	CONTRACTUAL ALLOW	4,336,463.63
NON-COVERD CHARGES	61,634.04	TOTAL MEDICAID LIAB	2,443,406.88
		LESS: COB	35,587.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,407,819.20

TOTAL NUMBER OF ADMISSIONS 343

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	810		0	582,757.19		14,318.11
ROUTINE NURSERY	128		0	77,166.04		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	938		0	659,923.23		14,318.11
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	765		2	1,043,879.30		1,936.82
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	765		2	1,043,879.30		1,936.82
TOTAL ACCOMODATIONS	1,703		2	1,703,802.53		16,254.93

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	743,116.87	0.00	OTHER LAB	19,233.32	0.00
MED/SURG SUPPLY	521,861.94	554.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	988,614.00	247.19	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	100,624.31	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	340,066.24	7,309.78	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	42,265.15	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,213.40	0.00	MRI SERVICES	33,423.33	0.00
IV THERAPY	26,216.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	171,127.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	76,727.63	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	354,662.26	21.44	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,372.54	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	162,084.17	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,858.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	23,163.06	0.00	INJECTABLE DRUGS	928,946.92	0.00
RADIOLOGY THERAPEUTIC	20,609.85	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,533.19	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,045.91	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	45,094.28	1,756.92	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,618.10	2,410.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,519.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,519.50
OTHER IMAGING SERVICE	22,087.63	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	74,606.81	25,624.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	72,877.60	935.28			
AUDIOLOGY	4,625.60	0.00			
CARDIOLOGY	124,014.49	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,628.42	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,229.91	0.00			
			TOTAL ANCILLARY	5,076,067.98	45,379.11
			TOTAL ACCOMODATIONS	1,703,802.53	16,254.93
			TOTAL CHARGES	6,779,870.51	61,634.04

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012065019349	02/21/12 - 02/26/12	03/12/12	0.00	1,629.92	0.00	0.00	0.00
615	2012065019349	02/21/12 - 02/26/12	03/12/12	0.00	1,629.83	0.00	0.00	0.00
615	2012275012964	07/09/12 - 07/13/12	10/08/12	0.00	3,259.75	0.00	0.00	0.00
TOTAL				0.00	6,519.50	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: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,176,528.54	ADJUSTMENTS	324,717.97
COVERED CHARGES	5,582,715.68	CONTRACTUAL ALLOW	4,160,198.03
NON-COVERD CHARGES	593,812.86	TOTAL MEDICAID LIAB	1,422,517.65
		LESS: COB	4,615.34
		LESS: COPAYMENT	6,495.00
		REIMBURSEMENT	1,411,407.31
		ALL OTHER	1,142,381.11
		FEE SCHEDULE-LAB	235,191.30
		INJECTABLE DRUGS	33,834.90

TOTAL NUMBER OF CLAIMS 4,909

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,461.38	3,015.41	OTHER LAB	33,552.82	793.27
MED/SURG SUPPLY	211,448.11	12,152.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	245,892.72	1,541.66	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	924,101.62	9,754.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,785.68	3,151.16	FEE SCHEDULE LAB	1,387,839.09	289,638.65
EKG/ECG	48,839.71	2,120.37	MRI SERVICES	97,377.35	1,629.83
IV THERAPY	137,990.96	9,955.27	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	248,875.26	17,436.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	250.89	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,305.98	8,404.91	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	128,019.95	7,144.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	612,270.71	11,073.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,938.21	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	157,448.37	103,137.69
RADIOLOGY THERAPEUTIC	401,244.23	2,298.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	916.35	324.93	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	542.39	1,879.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,655.23	2,852.42	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,594.08	6,665.85
LITHOTRIPSY	9,548.17	0.00	NO CC/INVALID REV CODE	0.00	13.01
OTHER IMAGING SERVICE	265,373.09	16,856.37			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,161.76	5,913.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	151,951.05	72,947.71			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	67,719.35	0.00			
AMBULATORY SURGERY	476.38	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	52,413.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	116,720.89	3,111.89			
			TOTAL ANCILLARY	5,582,715.68	593,812.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,582,715.68	593,812.86

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3641	5912269000829	08/31/12 - 08/31/12	10/01/12	0.00	13.01	0.00	0.00	0.00
TOTAL				0.00	13.01	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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

OCONEE REGIONAL MEDICAL CENTER  
821 N COBB ST  
MILLEDGEVILLE,GA 31061-2343

PROVIDER NUMBER  
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,566.84	ADJUSTMENTS	0.00
COVERED CHARGES	1,500.23	CONTRACTUAL ALLOW	1,200.10
NON-COVERD CHARGES	1,066.61	TOTAL MEDICAID LIAB	300.13
		LESS: COB	300.13
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	1,362.62	1,066.61
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	137.61	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,500.23	1,066.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,500.23	1,066.61

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	250,071.22	ADJUSTMENTS	1,179.68
COVERED CHARGES	233,631.27	CONTRACTUAL ALLOW	210,024.59
NON-COVERD CHARGES	16,439.95	TOTAL MEDICAID LIAB	23,606.68
		LESS: COB	39.41
		LESS: COPAYMENT	792.04
		REIMBURSEMENT	22,775.23
		TOTAL NUMBER OF CLAIMS	422

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,493.11	122.52	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,638.46	266.47	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,175.31	208.39	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,708.42	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,857.74	41.64	FEE SCHEDULE LAB	59,981.14	9,169.57
EKG/ECG	3,231.04	100.97	MRI SERVICES	0.00	0.00
IV THERAPY	3,712.97	265.93	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,445.87	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	339.78	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	100,333.33	1,084.61	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,471.58	3,446.22
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,641.65	1,733.63			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	600.87	0.00			
			TOTAL ANCILLARY	233,631.27	16,439.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	233,631.27	16,439.95

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: 09/24/2013  
Run Time: 14:13:56  
Page: 12

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,782.66	ADJUSTMENTS	0.00
COVERED CHARGES	1,723.83	CONTRACTUAL ALLOW	1,391.27
NON-COVERD CHARGES	58.83	TOTAL MEDICAID LIAB	332.56
		LESS: COB	332.56
		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: 09/24/2013  
 Run Time: 14:13:56  
 Page: 13

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	12.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	556.89	58.83
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	400.06	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	42.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	711.93	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,723.83	58.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,723.83	58.83

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: 09/24/2013  
Run Time: 14:13:57  
Page: 14

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	557,747.51	ADJUSTMENTS	5,315.11
COVERED CHARGES	552,253.70	CONTRACTUAL ALLOW	429,178.17
NON-COVERD CHARGES	5,493.81	TOTAL MEDICAID LIAB	123,075.53
		LESS: COB	0.00
		LESS: COPAYMENT	594.00
		REIMBURSEMENT	122,481.53
		TOTAL NUMBER OF CLAIMS	23

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,245.92	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	812.80	384.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	200,350.26	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,935.12	357.73
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,990.02	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	274.25	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	15,918.97	1,991.67
RADIOLOGY THERAPEUTIC	324,348.78	2,760.41	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	377.58	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	552,253.70	5,493.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	552,253.70	5,493.81



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

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

Run Date: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,062,138.27	ADJUSTMENTS	35,796.34
COVERED CHARGES	956,658.56	CONTRACTUAL ALLOW	537,189.64
NON-COVERD CHARGES	105,479.71	TOTAL MEDICAID LIAB	419,468.92
		LESS: COB	393.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	419,075.10

TOTAL NUMBER OF ADMISSIONS 74

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	237		35	141,955.00		77,835.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	237		35	141,955.00		77,835.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	40		0	58,360.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	40		0	58,360.00		0.00
TOTAL ACCOMODATIONS	277		35	200,315.00		77,835.00

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,222.86	0.00	OTHER LAB	4,485.00	0.00
MED/SURG SUPPLY	66,168.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	184,623.64	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,420.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,768.00	21,339.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,924.12	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,995.00	0.00	MRI SERVICES	6,925.00	0.00
IV THERAPY	8,524.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,442.93	4,027.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,580.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,497.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	69,681.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,355.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	960.00	0.00	INJECTABLE DRUGS	80,831.51	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,184.13	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,732.95	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	100.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,396.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,260.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,369.40	2,278.71			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	29,538.62	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,358.00	0.00			
			TOTAL ANCILLARY	756,343.56	27,644.71
			TOTAL ACCOMODATIONS	200,315.00	77,835.00
			TOTAL CHARGES	956,658.56	105,479.71

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

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

Run Date: 09/24/2013  
Run Time: 14:14:15  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000151A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 14:14:15  
Page: 4

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

PROVIDER NUMBER  
000000151A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,949,488.98	ADJUSTMENTS	79,404.59
COVERED CHARGES	1,732,433.75	CONTRACTUAL ALLOW	1,341,983.00
NON-COVERD CHARGES	217,055.23	TOTAL MEDICAID LIAB	390,450.75
		LESS: COB	414.28
		LESS: COPAYMENT	1,791.00
		REIMBURSEMENT	388,245.47
		ALL OTHER	343,249.11
		FEE SCHEDULE-LAB	37,201.16
		INJECTABLE DRUGS	7,795.20
		TOTAL NUMBER OF CLAIMS	1,505

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,769.36	10,836.58	OTHER LAB	43,281.00	0.00
MED/SURG SUPPLY	51,317.00	21.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	55.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	133,080.36	2,508.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	206,417.00	24,248.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,625.22	5,423.99	FEE SCHEDULE LAB	361,632.25	100,643.50
EKG/ECG	24,510.00	774.00	MRI SERVICES	108,133.00	3,293.00
IV THERAPY	34,230.62	1,853.42	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	104,488.00	15,582.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,014.85	802.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,768.00	1,463.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	428,556.09	9,448.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,036.00	5,417.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,310.58	28,534.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	712.00	494.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	499.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	686.43	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,871.00	2,450.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,670.34	681.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	715.00	312.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,310.00	1,177.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,804.08	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,683.00	350.00			
			TOTAL ANCILLARY	1,732,433.75	217,055.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,732,433.75	217,055.23

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

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

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Run Time: 14:15:03  
Page: 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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,094.04	ADJUSTMENTS	0.00
COVERED CHARGES	16,928.75	CONTRACTUAL ALLOW	9,888.79
NON-COVERD CHARGES	5,165.29	TOTAL MEDICAID LIAB	7,039.96
		LESS: COB	7,033.96
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

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

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313.27	40.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	507.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,949.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361.00	4,083.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,749.00	658.00
EKG/ECG	387.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,403.48	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	384.29
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	684.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	0.00			
			TOTAL ANCILLARY	16,928.75	5,165.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,928.75	5,165.29



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

Run Date: 09/24/2013  
Run Time: 14:15:04  
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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	257,866.83	ADJUSTMENTS	1,329.48
COVERED CHARGES	248,149.54	CONTRACTUAL ALLOW	228,458.67
NON-COVERD CHARGES	9,717.29	TOTAL MEDICAID LIAB	19,690.87
		LESS: COB	19.13
		LESS: COPAYMENT	597.05
		REIMBURSEMENT	19,074.69
		TOTAL NUMBER OF CLAIMS	352

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,463.77	353.62	OTHER LAB	711.00	0.00
MED/SURG SUPPLY	1,821.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,296.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,022.00	1,773.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	43,209.40	4,806.94
EKG/ECG	1,935.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	173.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	157,036.56	1,837.43	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,627.81	946.30
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	654.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	200.00	0.00			
			TOTAL ANCILLARY	248,149.54	9,717.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	248,149.54	9,717.29

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,460.54	ADJUSTMENTS	0.00
COVERED CHARGES	4,443.46	CONTRACTUAL ALLOW	2,742.41
NON-COVERD CHARGES	17.08	TOTAL MEDICAID LIAB	1,701.05
		LESS: COB	1,695.05
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63.98	5.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	239.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,712.48	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	12.08
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	4,443.46	17.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,443.46	17.08

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

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

Run Date: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 14:15:15  
Page: 13

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

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:15:23  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BERRIEN COUNTY HOSP  
 1221 E MCPHERSON AVE  
 NASHVILLE,GA 31639-2326

PROVIDER NUMBER 000000173A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	274,720.00	ADJUSTMENTS	7,009.82
COVERED CHARGES	246,260.00	CONTRACTUAL ALLOW	132,098.90
NON-COVERD CHARGES	28,460.00	TOTAL MEDICAID LIAB	114,161.10
		LESS: COB	1,817.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	112,343.92

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	100		0	40,000.00		28,460.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	100		0	40,000.00		28,460.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	100		0	40,000.00		28,460.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BERRIEN COUNTY HOSP  
 1221 E MCPHERSON AVE  
 NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,399.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,378.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,658.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,900.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,460.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	339.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,696.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,296.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,053.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,669.00	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	3,355.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	427.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	471.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,334.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,161.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,664.00	0.00			
			TOTAL ANCILLARY	206,260.00	0.00
			TOTAL ACCOMODATIONS	40,000.00	28,460.00
			TOTAL CHARGES	246,260.00	28,460.00



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

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

Run Date: 09/24/2013  
Run Time: 14:15:27  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 14:15:27  
Page: 4

BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	817,036.00	ADJUSTMENTS	23,098.11
COVERED CHARGES	748,542.00	CONTRACTUAL ALLOW	551,324.14
NON-COVERD CHARGES	68,494.00	TOTAL MEDICAID LIAB	197,217.86
		LESS: COB	0.00
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	196,482.86
		ALL OTHER	167,591.38
		FEE SCHEDULE-LAB	28,504.95
		INJECTABLE DRUGS	386.53

TOTAL NUMBER OF CLAIMS 1,079

BERRIEN COUNTY HOSP  
 1221 E MCPHERSON AVE  
 NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,848.00	153.00	OTHER LAB	3,822.00	0.00
MED/SURG SUPPLY	17,372.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,030.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,125.00	9,840.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,069.00	3,977.00	FEE SCHEDULE LAB	179,226.00	51,090.00
EKG/ECG	18,564.00	0.00	MRI SERVICES	9,101.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,626.00	246.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,106.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	254,194.00	1,641.00	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	1,136.00	424.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	308.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	35.00
OTHER IMAGING SERVICE	11,660.00	35.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,477.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,750.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,933.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,503.00	55.00			
			TOTAL ANCILLARY	748,542.00	67,804.00
			TOTAL ACCOMODATIONS	0.00	690.00
			TOTAL CHARGES	748,542.00	68,494.00

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: 09/24/2013  
Run Time: 14:15:27  
Page: 6

BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
31	2212181002427	04/27/12 - 04/27/12	07/02/12	0.00	35.00	0.00	0.00	0.00
TOTAL				0.00	35.00	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: 09/24/2013  
Run Time: 14:16:31  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,214.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,170.00	CONTRACTUAL ALLOW	1,165.31
NON-COVERD CHARGES	44.00	TOTAL MEDICAID LIAB	1,004.69
		LESS: COB	1,004.69
		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

BERRIEN COUNTY HOSP  
 1221 E MCPHERSON AVE  
 NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	475.00	44.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,554.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,170.00	44.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,170.00	44.00

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: 09/24/2013  
Run Time: 14:16:31  
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BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	96,036.00	ADJUSTMENTS	211.76
COVERED CHARGES	92,762.00	CONTRACTUAL ALLOW	82,828.44
NON-COVERD CHARGES	3,274.00	TOTAL MEDICAID LIAB	9,933.56
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	9,606.56
		TOTAL NUMBER OF CLAIMS	178

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

BERRIEN COUNTY HOSP  
 1221 E MCPHERSON AVE  
 NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,089.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	794.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,560.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,326.00	2,155.00
EKG/ECG	1,422.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	328.00	164.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,137.00	955.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	106.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	92,762.00	3,274.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,762.00	3,274.00



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: 09/24/2013  
Run Time: 14:16:37  
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BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 14:16:38  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 14:16:38  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BERRIEN COUNTY HOSP  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:16:45  
 Page: 1

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

PROVIDER NUMBER 000000195A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	222,994.65	ADJUSTMENTS	0.00
COVERED CHARGES	216,341.65	CONTRACTUAL ALLOW	31,391.71
NON-COVERD CHARGES	6,653.00	TOTAL MEDICAID LIAB	184,949.94
		LESS: COB	14,058.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	170,890.98
		TOTAL NUMBER OF ADMISSIONS	36

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	104		0	43,264.00		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	104		0	43,264.00		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	104		0	43,264.00		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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,238.35	0.00	OTHER LAB	440.00	0.00
MED/SURG SUPPLY	14,199.65	11.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,540.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,323.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,895.00	5,984.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,435.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,198.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,563.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,205.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	190.00	0.00	INJECTABLE DRUGS	39,595.90	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,782.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,841.00	449.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	679.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,952.00	0.00			
			TOTAL ANCILLARY	173,077.65	6,653.00
			TOTAL ACCOMODATIONS	43,264.00	0.00
			TOTAL CHARGES	216,341.65	6,653.00

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

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

Run Date: 09/24/2013  
Run Time: 14:16:55  
Page: 3

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 04/01/11 THROUGH 03/31/12  
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: 09/24/2013  
Run Time: 14:16:55  
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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	435,346.26	ADJUSTMENTS	17,074.66
COVERED CHARGES	370,624.89	CONTRACTUAL ALLOW	156,681.36
NON-COVERD CHARGES	64,721.37	TOTAL MEDICAID LIAB	213,943.53
		LESS: COB	2,401.31
		LESS: COPAYMENT	816.00
		REIMBURSEMENT	210,726.22
		ALL OTHER	184,668.29
		FEE SCHEDULE-LAB	21,686.07
		INJECTABLE DRUGS	4,371.86

TOTAL NUMBER OF CLAIMS 711

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,551.50	1,433.50	OTHER LAB	1,740.00	0.00
MED/SURG SUPPLY	11,821.60	324.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,796.00	2,832.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,837.00	4,488.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	100.00	0.00	FEE SCHEDULE LAB	136,417.49	40,483.02
EKG/ECG	6,694.00	200.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,834.00	2,520.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,665.30	370.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,107.50	8,164.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,535.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,006.50	3,906.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	679.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,200.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,640.00	0.00			
			TOTAL ANCILLARY	370,624.89	64,721.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	370,624.89	64,721.37



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

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

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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,544.25	ADJUSTMENTS	0.00
COVERED CHARGES	2,926.25	CONTRACTUAL ALLOW	1,337.81
NON-COVERD CHARGES	618.00	TOTAL MEDICAID LIAB	1,588.44
		LESS: COB	1,567.44
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,731.25	618.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	195.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,926.25	618.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,926.25	618.00

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: 09/24/2013  
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BLECKLEY MEMORIAL HOSP  
145 E PEACOCK ST  
COCHRAN,GA 31014-7846

PROVIDER NUMBER  
000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,578.30	ADJUSTMENTS	191.00
COVERED CHARGES	29,411.30	CONTRACTUAL ALLOW	24,511.30
NON-COVERD CHARGES	2,167.00	TOTAL MEDICAID LIAB	4,900.00
		LESS: COB	19.82
		LESS: COPAYMENT	195.01
		REIMBURSEMENT	4,685.17
		TOTAL NUMBER OF CLAIMS	98

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

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

Run Date: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	402.80	35.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	349.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,579.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	533.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,719.50	1,588.00
EKG/ECG	666.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,990.00	100.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,859.00	444.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	270.00	0.00			
			TOTAL ANCILLARY	29,411.30	2,167.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,411.30	2,167.00

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

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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	507.00	ADJUSTMENTS	0.00
COVERED CHARGES	470.00	CONTRACTUAL ALLOW	358.00
NON-COVERD CHARGES	37.00	TOTAL MEDICAID LIAB	112.00
		LESS: COB	112.00
		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: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	255.00	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	215.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	470.00	37.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	470.00	37.00

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

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

Run Date: 09/24/2013  
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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	04/01/11	THROUGH	03/31/12
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: 09/24/2013  
Run Time: 14:17:36  
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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	04/01/11	THROUGH	03/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	331,156.90	ADJUSTMENTS	4,739.27
COVERED CHARGES	327,468.90	CONTRACTUAL ALLOW	187,358.28
NON-COVERD CHARGES	3,688.00	TOTAL MEDICAID LIAB	140,110.62
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	140,110.62
			TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	107		0	57,887.00		3,125.00
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	107		0	57,887.00		3,125.00
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	107		0	57,887.00		3,125.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,718.90	0.00	OTHER LAB	545.00	0.00
MED/SURG SUPPLY	21,421.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	75,765.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,810.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,733.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,460.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,335.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,017.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,646.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	817.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	895.00	50.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,321.00	513.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,002.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68.00	0.00			
			TOTAL ANCILLARY	269,581.90	563.00
			TOTAL ACCOMODATIONS	57,887.00	3,125.00
			TOTAL CHARGES	327,468.90	3,688.00

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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,369,093.12	ADJUSTMENTS	56,885.55
COVERED CHARGES	1,172,866.36	CONTRACTUAL ALLOW	861,566.38
NON-COVERD CHARGES	196,226.76	TOTAL MEDICAID LIAB	311,299.98
		LESS: COB	0.00
		LESS: COPAYMENT	1,859.78
		REIMBURSEMENT	309,440.20
		ALL OTHER	254,766.20
		FEE SCHEDULE-LAB	53,787.11
		INJECTABLE DRUGS	886.89
		TOTAL NUMBER OF CLAIMS	1,783

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,387.86	35,873.16	OTHER LAB	2,110.00	0.00
MED/SURG SUPPLY	10,750.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	230.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,772.00	371.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	146,539.00	10,955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,131.00	18,693.00	FEE SCHEDULE LAB	434,572.50	94,381.40
EKG/ECG	10,448.00	241.00	MRI SERVICES	34,755.00	0.00
IV THERAPY	41,263.00	3,768.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,183.00	1,271.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	187,444.00	843.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	40.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,621.00	4,659.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,769.00	14,455.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	333.00	8,742.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	67.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	59.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,751.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,578.00	1,578.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,385.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,870.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,204.00	0.00			
			TOTAL ANCILLARY	1,172,866.36	196,226.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,172,866.36	196,226.76

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,372.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,080.00	CONTRACTUAL ALLOW	-536.78
NON-COVERD CHARGES	1,292.00	TOTAL MEDICAID LIAB	1,616.78
		LESS: COB	1,616.78
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,292.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	380.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	84.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	550.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,080.00	1,292.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,080.00	1,292.00

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,177.00	ADJUSTMENTS	341.00
COVERED CHARGES	66,231.00	CONTRACTUAL ALLOW	61,131.00
NON-COVERD CHARGES	2,946.00	TOTAL MEDICAID LIAB	5,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	144.00
		REIMBURSEMENT	4,956.00
		TOTAL NUMBER OF CLAIMS	102



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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777.00	36.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	558.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,485.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,323.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,666.00	2,567.00
EKG/ECG	360.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,507.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	281.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,117.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,043.00	343.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	114.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	66,231.00	2,946.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,231.00	2,946.00

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	625.00	ADJUSTMENTS	0.00
COVERED CHARGES	625.00	CONTRACTUAL ALLOW	151.67
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	473.33
		LESS: COB	473.33
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	275.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	350.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	625.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	625.00	0.00

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

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	426,823.80	ADJUSTMENTS	12,705.87
COVERED CHARGES	419,363.80	CONTRACTUAL ALLOW	372,280.61
NON-COVERD CHARGES	7,460.00	TOTAL MEDICAID LIAB	47,083.19
		LESS: COB	0.00
		LESS: COPAYMENT	489.00
		REIMBURSEMENT	46,594.19
		TOTAL NUMBER OF CLAIMS	11

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321,810.80	5,555.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	86.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,404.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56,043.00	1,819.00
EKG/ECG	545.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,266.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	295.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	419,363.80	7,460.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	419,363.80	7,460.00

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: 09/24/2013  
Run Time: 14:18:42  
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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:18:51  
 Page: 1

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,880,774.18	ADJUSTMENTS	258,304.20
COVERED CHARGES	23,614,507.98	CONTRACTUAL ALLOW	17,921,473.23
NON-COVERD CHARGES	266,266.20	TOTAL MEDICAID LIAB	5,693,034.75
		LESS: COB	72,457.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,620,577.13

TOTAL NUMBER OF ADMISSIONS 946

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,650		2	741,390.00		78,970.00
ROUTINE NURSERY	374		0	154,150.00		1,775.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		870.00
TOTAL ROUTINE	2,024		2	895,540.00		81,615.00
SPECIAL CARE SERVICES						
CCU	158		0	157,480.00		0.00
ICU	1,375		0	1,131,049.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,533		0	1,288,529.00		0.00
TOTAL ACCOMODATIONS	3,557		2	2,184,069.00		81,615.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,495,658.43	0.00	OTHER LAB	123,804.95	0.00
MED/SURG SUPPLY	4,436,038.22	8,142.63	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,438,294.54	0.00	EDUCATION & TRAINING	14,385.20	0.00
RADIOLOGY-DIAGNOSTIC	571,670.63	39,118.01	OTHER THERAPEUTIC SVC	0.00	7,762.82
CT SCAN	1,360,502.63	2,510.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	143,693.71	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	126,309.14	0.00	MRI SERVICES	330,316.89	0.00
IV THERAPY	72.77	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,402,210.90	0.00	DURABLE MED. EQUIP.	0.00	374.47
LABOR/DELIVERY ROOM	598,086.77	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	346,152.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	520,581.74	0.00	AMBULANCE	0.00	0.00
GI SERVICES	177,752.06	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,012,073.41	0.00	SPECIAL SERVICES	0.00	4,524.00
RECOVERY ROOM	112,537.19	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	146,317.29	0.00	INJECTABLE DRUGS	822.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	31,618.81	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,236.89	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	83,452.22	9,212.70	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	454.42	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	382,365.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	64,157.64
OTHER IMAGING SERVICE	106,444.57	5,774.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	204,533.80	21,773.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	124,800.81	21,300.02			
AUDIOLOGY	6,040.00	0.00			
CARDIOLOGY	1,035,295.33	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,391.94	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,522.76	0.00			
			TOTAL ANCILLARY	21,430,438.98	184,651.20
			TOTAL ACCOMODATIONS	2,184,069.00	81,615.00
			TOTAL CHARGES	23,614,507.98	266,266.20



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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2011298001352	10/09/11 - 10/09/11	10/31/11	0.00	2,341.45	0.00	0.00	0.00
615	2011339006350	11/06/11 - 11/06/11	12/12/11	0.00	5,870.49	0.00	0.00	0.00
615	2012055047951	02/01/12 - 02/05/12	02/27/12	0.00	2,630.62	0.00	0.00	0.00
615	2012055048233	01/30/12 - 02/07/12	02/27/12	0.00	2,630.62	0.00	0.00	0.00
615	5912058001200	01/11/12 - 01/16/12	03/05/12	0.00	2,630.62	0.00	0.00	0.00
615	9112037014681	11/07/11 - 11/07/11	03/05/12	0.00	2,630.62	0.00	1,436.90	0.00
615	2012087082955	03/14/12 - 03/20/12	04/02/12	0.00	2,630.62	0.00	0.00	0.00
615	2012112024489	04/08/12 - 04/17/12	04/30/12	0.00	2,630.62	0.00	0.00	0.00
615	2012119028079	04/20/12 - 04/24/12	05/07/12	0.00	2,630.62	0.00	0.00	0.00
615	2012143037404	05/07/12 - 05/18/12	05/28/12	0.00	2,630.62	0.00	0.00	0.00
615	2012152051796	05/23/12 - 05/24/12	06/04/12	0.00	2,630.62	0.00	0.00	0.00
615	2012169000138	04/11/12 - 04/13/12	06/25/12	0.00	2,630.62	0.00	0.00	0.00
615	2012216026798	07/28/12 - 07/29/12	08/06/12	0.00	2,630.62	0.00	0.00	0.00
418	5912223000992	07/04/12 - 07/04/12	08/13/12	0.00	93.43	0.00	0.00	0.00
615	2012235049110	07/12/12 - 07/16/12	08/27/12	0.00	2,630.62	0.00	0.00	0.00
615	2012250034218	08/21/12 - 08/26/12	09/10/12	0.00	2,630.62	0.00	0.00	0.00
615	2012279041749	09/11/12 - 10/02/12	10/08/12	0.00	2,630.62	0.00	0.00	0.00
615	2012283010015	09/29/12 - 10/01/12	10/15/12	0.00	2,630.62	0.00	0.00	0.00
615	9112310004238	04/20/12 - 04/22/12	11/12/12	0.00	2,630.62	0.00	980.02	0.00
615	2212354000504	04/15/12 - 04/19/12	12/24/12	0.00	5,870.49	0.00	0.00	0.00
615	9112356005265	04/19/12 - 04/21/12	01/21/13	0.00	2,630.62	0.00	957.83	0.00
615	2213071008023	04/05/12 - 04/06/12	03/18/13	0.00	2,630.62	0.00	0.00	0.00
615	9113064002647	06/03/12 - 06/06/12	04/01/13	0.00	2,630.62	0.00	1,277.14	0.00
TOTAL				0.00	64,157.64	0.00	4,651.89	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: 09/24/2013  
 Run Time: 14:20:09  
 Page: 4

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	286,773.12	ADJUSTMENTS	0.00
COVERED CHARGES	282,358.08	CONTRACTUAL ALLOW	144,752.43
NON-COVERD CHARGES	4,415.04	TOTAL MEDICAID LIAB	137,605.65
		LESS: COB	137,605.65
		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	35		0	15,705.00		1,660.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	35		0	15,705.00		1,660.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,005.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	1,005.00		0.00
TOTAL ACCOMODATIONS	36		0	16,710.00		1,660.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,891.84	0.00	OTHER LAB	654.68	0.00
MED/SURG SUPPLY	69,407.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,595.05	0.00	EDUCATION & TRAINING	394.77	0.00
RADIOLOGY-DIAGNOSTIC	2,283.94	0.00	OTHER THERAPEUTIC SVC	0.00	124.42
CT SCAN	10,950.87	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	505.94	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	910.02	0.00	MRI SERVICES	3,895.98	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,051.29	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50,050.87	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	256.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,620.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,586.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	839.53	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	438.04	0.00	INJECTABLE DRUGS	1,843.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	933.09	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	634.35	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	98.16	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,630.62
OTHER IMAGING SERVICE	591.23	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,991.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,415.62	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	808.09	0.00			
			TOTAL ANCILLARY	265,648.08	2,755.04
			TOTAL ACCOMODATIONS	16,710.00	1,660.00
			TOTAL CHARGES	282,358.08	4,415.04

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

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

Run Date: 09/24/2013  
Run Time: 14:20:09  
Page: 6

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212208016155	05/22/12 - 05/24/12	07/30/12	0.00	2,630.62	0.00	18,402.41	0.00
TOTAL				0.00	2,630.62	0.00	18,402.41	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: 09/24/2013  
Run Time: 14:20:13  
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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,658,999.67	ADJUSTMENTS	699,603.03
COVERED CHARGES	14,913,196.03	CONTRACTUAL ALLOW	12,060,250.57
NON-COVERD CHARGES	1,745,803.64	TOTAL MEDICAID LIAB	2,852,945.46
		LESS: COB	8,814.49
		LESS: COPAYMENT	5,434.10
		REIMBURSEMENT	2,838,696.87
		ALL OTHER	2,678,352.02
		FEE SCHEDULE-LAB	135,716.64
		INJECTABLE DRUGS	24,628.21

TOTAL NUMBER OF CLAIMS 5,313

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,336.47	101,492.09	OTHER LAB	700,351.97	19,875.54
MED/SURG SUPPLY	1,573,418.20	13,009.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,246.43	EDUCATION & TRAINING	442.50	1,275.09
RADIOLOGY-DIAGNOSTIC	722,014.33	80,511.07	OTHER THERAPEUTIC SVC	0.00	56,041.34
CT SCAN	1,804,223.21	171,541.31	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	132.42	2,364.84	FEE SCHEDULE LAB	2,290,736.84	557,550.40
EKG/ECG	83,490.99	2,123.38	MRI SERVICES	468,150.26	71,242.73
IV THERAPY	9,963.03	2,580.23	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	712,327.69	128,925.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,150.81	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	320,037.91	13,474.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	366,326.93	49,239.96	AMBULANCE	0.00	0.00
GI SERVICES	173,351.75	48,519.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,101,203.35	15,513.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	159,731.22	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	565.12	INJECTABLE DRUGS	592,941.59	195,129.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	457.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,677.77	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,510.52	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,507.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	82,011.09	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	795.00	551.03
OTHER IMAGING SERVICE	306,900.87	50,796.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,838.08	3,965.86			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	174,484.30	37,633.64			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	607,860.69	104,360.43			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,661.71	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	533,312.82	4,121.84			
			TOTAL ANCILLARY	14,913,196.03	1,745,803.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,913,196.03	1,745,803.64

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

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

Run Date: 09/24/2013  
Run Time: 14:20:13  
Page: 9

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	1012055005956	01/02/12 - 01/02/12	03/05/12	795.00	0.00	0.00	0.00	0.00
418	5912079001340	02/25/12 - 02/25/12	03/26/12	0.00	5.32	0.00	0.00	0.00
418	5912079001340	02/25/12 - 02/25/12	03/26/12	0.00	14.48	0.00	0.00	0.00
418	5912079001340	02/25/12 - 02/25/12	03/26/12	0.00	309.84	0.00	0.00	0.00
418	5912264002208	08/22/12 - 08/22/12	09/24/12	0.00	19.19	0.00	0.00	0.00
438	2212265017310	05/25/12 - 05/25/12	09/24/12	0.00	65.94	0.00	0.00	0.00
438	2212265017310	05/25/12 - 05/25/12	09/24/12	0.00	50.98	0.00	0.00	0.00
438	2212265017310	05/25/12 - 05/25/12	09/24/12	0.00	85.28	0.00	0.00	0.00
436	5912289000356	07/24/12 - 07/24/12	10/22/12	0.00	0.00	0.00	0.00	0.00
TOTAL				795.00	551.03	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: 09/24/2013  
Run Time: 14:23:02  
Page: 10

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	523,003.60	ADJUSTMENTS	0.00
COVERED CHARGES	388,347.63	CONTRACTUAL ALLOW	151,087.74
NON-COVERD CHARGES	134,655.97	TOTAL MEDICAID LIAB	237,259.89
		LESS: COB	237,171.73
		LESS: COPAYMENT	88.16
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 135



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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,115.89	3,054.65	OTHER LAB	29,110.98	0.00
MED/SURG SUPPLY	63,892.76	173.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,221.64	0.00	OTHER THERAPEUTIC SVC	0.00	5,640.58
CT SCAN	10,662.82	32,492.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	729.54	FEE SCHEDULE LAB	70,464.71	11,578.20
EKG/ECG	2,275.05	0.00	MRI SERVICES	8,423.06	14,348.00
IV THERAPY	527.17	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,476.62	9,091.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	264.72	174.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,641.57	1,102.59	AMBULANCE	0.00	0.00
GI SERVICES	859.38	3,001.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	73,745.62	1,207.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,992.89	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,062.61	8,080.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	353.30	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	634.35	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	319.51	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,684.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,542.72	19,230.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,417.37	3,523.71			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,991.30	19,461.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,974.32	457.68			
			TOTAL ANCILLARY	388,347.63	134,655.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	388,347.63	134,655.97

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: 09/24/2013  
Run Time: 14:23:09  
Page: 12

EAST GA REGIONAL MEDICAL CTR., LLC  
1499 FAIR RD  
STATESBORO,GA 30458-1683

PROVIDER NUMBER  
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,858,237.36	ADJUSTMENTS	4,307.16
COVERED CHARGES	1,743,660.95	CONTRACTUAL ALLOW	1,690,685.78
NON-COVERD CHARGES	114,576.41	TOTAL MEDICAID LIAB	52,975.17
		LESS: COB	10.47
		LESS: COPAYMENT	1,665.16
		REIMBURSEMENT	51,299.54
		TOTAL NUMBER OF CLAIMS	947

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,088.10	25,673.24	OTHER LAB	25,050.66	2,900.10
MED/SURG SUPPLY	63,349.36	293.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	29.50	0.00
RADIOLOGY-DIAGNOSTIC	107,590.22	0.00	OTHER THERAPEUTIC SVC	0.00	1,219.87
CT SCAN	147,493.32	23,084.67	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	259,844.83	39,148.78
EKG/ECG	9,947.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,827.90	349.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,008,391.06	776.63	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	61,976.74	10,498.86
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	98.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	455.08
OTHER IMAGING SERVICE	47,623.32	9,980.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,266.36	97.21			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,182.46	0.00			
			TOTAL ANCILLARY	1,743,660.95	114,576.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,743,660.95	114,576.41

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: 09/24/2013  
Run Time: 14:23:09  
Page: 14

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
418	5912073000758	02/23/12 - 02/23/12	03/19/12	0.00	14.48	0.00	0.00	0.00
418	5912073000758	02/23/12 - 02/23/12	03/19/12	0.00	131.76	0.00	0.00	0.00
418	5912095000937	03/15/12 - 03/15/12	04/09/12	0.00	308.84	0.00	0.00	0.00
TOTAL				0.00	455.08	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

Run Date: 09/24/2013  
Run Time: 14:23:37  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,061.11	ADJUSTMENTS	0.00
COVERED CHARGES	40,830.29	CONTRACTUAL ALLOW	20,323.48
NON-COVERD CHARGES	3,230.82	TOTAL MEDICAID LIAB	20,506.81
		LESS: COB	20,482.81
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	19

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

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

Run Date: 09/24/2013  
 Run Time: 14:23:37  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212.39	557.89	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,634.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,342.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,523.83	1,135.46
EKG/ECG	151.67	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33.72	87.40	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	22,903.29	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,475.75	623.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	552.55	826.25			
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	40,830.29	3,230.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,830.29	3,230.82

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

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

Run Date: 09/24/2013  
Run Time: 14:23:40  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,418,945.91	ADJUSTMENTS	406,880.50
COVERED CHARGES	6,734,351.14	CONTRACTUAL ALLOW	5,884,020.35
NON-COVERD CHARGES	684,594.77	TOTAL MEDICAID LIAB	850,330.79
		LESS: COB	4,553.96
		LESS: COPAYMENT	661.87
		REIMBURSEMENT	845,114.96

TOTAL NUMBER OF CLAIMS 167

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,200.82	33,028.29	OTHER LAB	4,821.80	966.70
MED/SURG SUPPLY	2,146,856.78	586.71	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	11.24	EDUCATION & TRAINING	29.50	82.72
RADIOLOGY-DIAGNOSTIC	41,549.01	20,333.75	OTHER THERAPEUTIC SVC	0.00	5,414.25
CT SCAN	33,652.98	42,694.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	264.84	847.02	FEE SCHEDULE LAB	161,120.11	42,078.50
EKG/ECG	10,675.30	2,561.72	MRI SERVICES	24,263.38	9,230.02
IV THERAPY	402.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,680,872.68	381,369.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,705.64	524.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	418,641.78	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,253.74	1,322.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,077.37	839.53	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	178,938.02	110,706.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	481.31	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	996.65	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	682,304.90	0.00
LITHOTRIPSY	24,588.92	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,364.78	2,656.66			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,643.54	1,348.24			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,010,067.41	26,513.31			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,415.62	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,639.74	0.00			
			TOTAL ANCILLARY	6,734,351.14	684,594.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,734,351.14	684,594.77



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: 09/24/2013  
Run Time: 14:23:48  
Page: 19

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,280.81	ADJUSTMENTS	0.00
COVERED CHARGES	63,051.17	CONTRACTUAL ALLOW	26,830.88
NON-COVERD CHARGES	1,229.64	TOTAL MEDICAID LIAB	36,220.29
		LESS: COB	36,217.29
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

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

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

Run Date: 09/24/2013  
 Run Time: 14:23:48  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC  
 1499 FAIR RD  
 STATESBORO,GA 30458-1683

PROVIDER NUMBER  
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	376.69	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,881.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	628.71	5.62
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,709.47	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,816.83	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,854.27	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	421.32	847.33
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	2,316.08	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,422.57	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	63,051.17	1,229.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,051.17	1,229.64

\*\* END 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: 09/24/2013  
 Run Time: 14:23:57  
 Page: 1

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 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	481,938.08	ADJUSTMENTS	9,877.27
COVERED CHARGES	480,683.08	CONTRACTUAL ALLOW	78,278.79
NON-COVERD CHARGES	1,255.00	TOTAL MEDICAID LIAB	402,404.29
		LESS: COB	4,757.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	397,646.53

TOTAL NUMBER OF ADMISSIONS 124

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	242		0	76,365.00		1,075.00
ROUTINE NURSERY	60		0	11,100.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	302		0	87,465.00		1,075.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	302		0	87,465.00		1,075.00

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

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

Run Date: 09/24/2013  
 Run Time: 14:23:57  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	114,110.07	0.00	OTHER LAB	350.00	0.00
MED/SURG SUPPLY	87,265.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	55,812.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,650.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,305.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,862.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,910.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,020.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,203.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,006.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,610.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,305.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,995.00	180.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,412.00	0.00			
CARDIOLOGY	800.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	393,218.08	180.00
			TOTAL ACCOMODATIONS	87,465.00	1,075.00
			TOTAL CHARGES	480,683.08	1,255.00

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: 09/24/2013  
 Run Time: 14:24:08  
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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 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,629.41	ADJUSTMENTS	0.00
COVERED CHARGES	6,609.41	CONTRACTUAL ALLOW	2,067.67
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	4,541.74
		LESS: COB	4,541.74
		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	1,260.00		20.00
ROUTINE NURSERY	1		0	185.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	1,445.00		20.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,445.00		20.00

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 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	836.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,307.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	794.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,200.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	343.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	555.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	67.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,164.41	0.00
			TOTAL ACCOMODATIONS	1,445.00	20.00
			TOTAL CHARGES	6,609.41	20.00

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: 09/24/2013  
Run Time: 14:24:09  
Page: 5

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 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	741,124.12	ADJUSTMENTS	88,232.19
COVERED CHARGES	701,384.92	CONTRACTUAL ALLOW	354,785.65
NON-COVERD CHARGES	39,739.20	TOTAL MEDICAID LIAB	346,599.27
		LESS: COB	444.02
		LESS: COPAYMENT	1,422.00
		REIMBURSEMENT	344,733.25
		ALL OTHER	317,636.38
		FEE SCHEDULE-LAB	26,592.47
		INJECTABLE DRUGS	504.40
		TOTAL NUMBER OF CLAIMS	1,264

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

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

Run Date: 09/24/2013  
 Run Time: 14:24:09  
 Page: 6

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 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,193.21	990.50	OTHER LAB	5,115.00	0.00
MED/SURG SUPPLY	67,959.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,505.00	640.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	56,745.00	8,430.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	88,667.10	16,387.20
EKG/ECG	11,479.00	103.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,388.00	880.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,500.00	2,375.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,315.00	40.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,537.50	643.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,693.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,200.00	725.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	126,753.00	1,390.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,100.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,293.00	1,841.00
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	3,320.50	51.50	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	53,475.00	3,680.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,980.00	540.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,400.00	390.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,765.00	450.00			
			TOTAL ANCILLARY	701,384.92	39,556.70
			TOTAL ACCOMODATIONS	0.00	182.50
			TOTAL CHARGES	701,384.92	39,739.20



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

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

Run Date: 09/24/2013  
Run Time: 14:24:51  
Page: 7

SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	261.84	ADJUSTMENTS	0.00
COVERED CHARGES	261.84	CONTRACTUAL ALLOW	120.84
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	141.00
		LESS: COB	141.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

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 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	195.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	261.84	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	261.84	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: 09/24/2013  
Run Time: 14:24:51  
Page: 9

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 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,021.09	ADJUSTMENTS	308.64
COVERED CHARGES	34,074.09	CONTRACTUAL ALLOW	26,944.32
NON-COVERD CHARGES	947.00	TOTAL MEDICAID LIAB	7,129.77
		LESS: COB	0.00
		LESS: COPAYMENT	207.00
		REIMBURSEMENT	6,922.77
		TOTAL NUMBER OF CLAIMS	131

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 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,288.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,643.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	970.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,355.60	624.00
EKG/ECG	412.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,116.50	40.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	190.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,235.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,223.00	83.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	380.00	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	2,010.00	0.00			
			TOTAL ANCILLARY	34,074.09	947.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,074.09	947.00

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: 09/24/2013  
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Page: 11

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	06/01/11	THROUGH	05/31/12
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: 09/24/2013  
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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 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,937.76	ADJUSTMENTS	4,770.68
COVERED CHARGES	9,718.76	CONTRACTUAL ALLOW	4,948.08
NON-COVERD CHARGES	219.00	TOTAL MEDICAID LIAB	4,770.68
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,770.68

TOTAL NUMBER OF CLAIMS 1

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 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	803.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,900.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	554.40	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	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	481.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	250.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,980.00	180.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,700.00	0.00			
			TOTAL ANCILLARY	9,718.76	219.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,718.76	219.00

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: 09/24/2013  
Run Time: 14:24:57  
Page: 14

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	06/01/11	THROUGH	05/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:25:04  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,296,558.47	ADJUSTMENTS	3,732,766.29
COVERED CHARGES	51,815,530.47	CONTRACTUAL ALLOW	30,539,579.84
NON-COVERD CHARGES	1,481,028.00	TOTAL MEDICAID LIAB	21,275,950.63
		LESS: COB	237,853.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,038,097.46

TOTAL NUMBER OF ADMISSIONS 3,415

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,693		0	6,812,872.00		704,309.00
ROUTINE NURSERY	2,455		1	1,997,986.00		214.00
SWING BED	0		5	0.00		10,545.00
LEAVE OF ABSENCE	0		0	0.00		4,283.00
TOTAL ROUTINE	10,148		6	8,810,858.00		719,351.00
SPECIAL CARE SERVICES						
CCU	21		0	77,900.00		0.00
ICU	1,801		0	3,143,057.00		4,218.00
NICU	1,735		0	3,845,041.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		19	0.00		862.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,557		19	7,065,998.00		5,080.00
TOTAL ACCOMODATIONS	13,705		25	15,876,856.00		724,431.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,540,182.50	5,953.00	OTHER LAB	407,182.00	0.00
MED/SURG SUPPLY	527,688.00	31,072.00	RECREATIONAL THERAPY	140.00	0.00
LABORATORY-GENERAL	4,391,148.97	6,934.00	EDUCATION & TRAINING	11,982.00	78.00
RADIOLOGY-DIAGNOSTIC	1,754,657.00	596.00	OTHER THERAPEUTIC SVC	0.00	7,988.00
CT SCAN	3,237,437.00	148,683.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	186,612.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	343,845.00	273.00	MRI SERVICES	544,704.00	0.00
IV THERAPY	120,641.00	197.00	PROFESSIONAL FEES	0.00	1,118.00
OPERATING ROOM	5,085,903.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	482,971.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,227,548.00	15,746.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,704,395.00	914.00	AMBULANCE	0.00	0.00
GI SERVICES	265,681.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,345,521.00	37,111.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,290,039.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	376,084.00	0.00	INJECTABLE DRUGS	3,201,017.00	3,613.00
RADIOLOGY THERAPEUTIC	6,951.00	1,128.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	57,776.00	812.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,996.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	30,000.00	380,800.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	100.00	1,636.00	TRAUMA RESPONSE	0.00	30,177.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	904,184.00	28.00
LITHOTRIPSY	20,000.00	0.00	NO CC/INVALID REV CODE	0.00	36,045.00
OTHER IMAGING SERVICE	504,763.00	19,638.00			
BLOOD	404.00	0.00			
BLOOD STORAGE & PRO.	327,514.00	17,119.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	413,503.00	0.00			
AUDIOLOGY	37,605.00	69.00			
CARDIOLOGY	1,457,403.00	1,960.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,120.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	60,977.00	6,909.00			
			TOTAL ANCILLARY	35,938,674.47	756,597.00
			TOTAL ACCOMODATIONS	15,876,856.00	724,431.00
			TOTAL CHARGES	51,815,530.47	1,481,028.00

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

PROVIDER NUMBER  
 000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
39	2212011000606	12/04/11 - 12/05/11	01/16/12	0.00	23.00	0.00	0.00	0.00
714	2212027007310	12/13/11 - 12/27/11	01/30/12	0.00	2,220.00	0.00	0.00	0.00
378	2212037001906	11/04/11 - 11/08/11	02/13/12	0.00	937.00	0.00	0.00	0.00
615	2012192055260	04/21/12 - 04/22/12	07/16/12	0.00	2,625.00	0.00	0.00	0.00
615	2312208000058	01/08/12 - 02/03/12	09/03/12	0.00	2,625.00	0.00	0.00	0.00
615	2312230000043	02/24/12 - 03/02/12	10/15/12	0.00	2,625.00	0.00	0.00	0.00
615	2012240035504	01/20/12 - 01/22/12	09/03/12	0.00	4,830.00	0.00	0.00	0.00
615	2012251088514	06/24/12 - 06/26/12	09/17/12	0.00	2,625.00	0.00	0.00	0.00
615	2212341012706	02/28/12 - 04/27/12	12/10/12	0.00	2,625.00	0.00	0.00	0.00
615	2213080012724	11/29/11 - 03/05/12	03/25/13	0.00	4,830.00	0.00	2,646.06	0.00
615	2213084000202	06/12/12 - 06/20/12	04/01/13	0.00	4,830.00	0.00	0.00	0.00
615	5213136000105	04/07/12 - 05/03/12	06/24/13	0.00	2,625.00	0.00	0.00	0.00
615	2013170068577	03/06/12 - 03/13/12	06/24/13	0.00	2,625.00	0.00	0.00	0.00
TOTAL				0.00	36,045.00	0.00	2,646.06	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: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	339,675.00	ADJUSTMENTS	0.00
COVERED CHARGES	339,475.00	CONTRACTUAL ALLOW	128,633.33
NON-COVERD CHARGES	200.00	TOTAL MEDICAID LIAB	210,841.67
		LESS: COB	210,841.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	51		11	45,645.00		200.00
ROUTINE NURSERY	34		0	47,010.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	85		11	92,655.00		200.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	14		0	19,502.00		0.00
NICU	27		0	57,942.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	77,444.00		0.00
TOTAL ACCOMODATIONS	126		11	170,099.00		200.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,672.00	0.00	OTHER LAB	1,333.00	0.00
MED/SURG SUPPLY	2,066.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,617.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,597.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,400.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	368.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	546.00	0.00	MRI SERVICES	6,012.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,559.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,667.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,621.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,520.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,215.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,476.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	561.00	0.00	INJECTABLE DRUGS	14,909.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	220.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	309.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,241.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,303.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,559.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	345.00	0.00			
CARDIOLOGY	1,260.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	169,376.00	0.00
			TOTAL ACCOMODATIONS	170,099.00	200.00
			TOTAL CHARGES	339,475.00	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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,386,904.76	ADJUSTMENTS	816,539.12
COVERED CHARGES	20,520,135.26	CONTRACTUAL ALLOW	16,368,356.82
NON-COVERD CHARGES	4,866,769.50	TOTAL MEDICAID LIAB	4,151,778.44
		LESS: COB	4,364.55
		LESS: COPAYMENT	8,282.63
		REIMBURSEMENT	4,139,131.26
		ALL OTHER	3,606,998.04
		FEE SCHEDULE-LAB	306,306.42
		INJECTABLE DRUGS	225,826.80

TOTAL NUMBER OF CLAIMS 9,176

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	802,402.00	9,042.00	OTHER LAB	248,907.00	44,074.00
MED/SURG SUPPLY	91,477.00	148,944.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	880.00	EDUCATION & TRAINING	162.00	820.00
RADIOLOGY-DIAGNOSTIC	1,068,361.00	45,243.00	OTHER THERAPEUTIC SVC	0.00	14,593.00
CT SCAN	2,374,283.00	1,089,863.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,384.00	3,827.00	FEE SCHEDULE LAB	2,798,146.26	424,049.50
EKG/ECG	308,483.00	5,187.00	MRI SERVICES	567,048.00	124,927.00
IV THERAPY	304,001.00	38,635.00	PROFESSIONAL FEES	0.00	456.00
OPERATING ROOM	1,646,378.00	906,176.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,995.00	2,954.00	REHAB THERAPY	432.00	0.00
RESPIRATORY SERVICES	61,475.00	31,497.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	587,360.00	4,260.00	AMBULANCE	0.00	0.00
GI SERVICES	165,671.00	63,949.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,636,423.00	116,323.00	SPECIAL SERVICES	0.00	646.00
RECOVERY ROOM	805,506.00	8,012.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,496,401.00	928,182.00
RADIOLOGY THERAPEUTIC	127,575.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,078.00	1,176.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	257.00	584.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	49,029.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	53,354.00	550.00	TRAUMA RESPONSE	0.00	22,992.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,262.00	196,219.00
LITHOTRIPSY	20,000.00	0.00	NO CC/INVALID REV CODE	0.00	304.00
OTHER IMAGING SERVICE	1,159,131.00	85,490.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,100.00	25,175.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	387,786.00	211,912.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	401,072.00	258,723.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,862.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	247,363.00	161.00			
			TOTAL ANCILLARY	20,520,135.26	4,864,854.50
			TOTAL ACCOMODATIONS	0.00	1,915.00
			TOTAL CHARGES	20,520,135.26	4,866,769.50

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2211353005446	08/02/11 - 08/02/11	12/26/11	0.00	109.00	0.00	0.00	0.00
948	2212102002376	12/22/11 - 12/22/11	04/16/12	0.00	195.00	0.00	0.00	0.00
TOTAL				0.00	304.00	0.00	0.00	0.00



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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	299,965.00	ADJUSTMENTS	0.00
COVERED CHARGES	230,709.00	CONTRACTUAL ALLOW	163,034.42
NON-COVERD CHARGES	69,256.00	TOTAL MEDICAID LIAB	67,674.58
		LESS: COB	67,577.69
		LESS: COPAYMENT	96.89
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,310.00	326.00	OTHER LAB	5,070.00	0.00
MED/SURG SUPPLY	1,126.00	827.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,928.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,952.00	10,694.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,014.00	5,718.00
EKG/ECG	3,998.00	273.00	MRI SERVICES	3,014.00	0.00
IV THERAPY	8,919.00	107.00	PROFESSIONAL FEES	0.00	43.00
OPERATING ROOM	17,573.00	945.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,699.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	394.00	420.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,977.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,955.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,807.00	946.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,841.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	100.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,430.00	39,622.00
RADIOLOGY THERAPEUTIC	4,283.00	0.00	HOME HEALTH SERVICES	0.00	348.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	332.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	255.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,490.00	7,350.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,260.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,337.00	0.00			
			TOTAL ANCILLARY	230,709.00	69,256.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	230,709.00	69,256.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	862,768.00	ADJUSTMENTS	1,397.42
COVERED CHARGES	776,400.00	CONTRACTUAL ALLOW	734,389.08
NON-COVERD CHARGES	86,368.00	TOTAL MEDICAID LIAB	42,010.92
		LESS: COB	35.56
		LESS: COPAYMENT	795.04
		REIMBURSEMENT	41,180.32
		TOTAL NUMBER OF CLAIMS	751

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,232.00	0.00	OTHER LAB	10,765.00	6,780.00
MED/SURG SUPPLY	1,693.00	973.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,388.00	997.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,979.00	34,918.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	137,100.00	19,547.00
EKG/ECG	10,374.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,188.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,478.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,412.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,540.00	180.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,466.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	449,973.00	1,697.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,122.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,305.00	7,652.00
RADIOLOGY THERAPEUTIC	1,998.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,166.00	9,321.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,178.00	3,021.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,260.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	783.00	0.00			
			TOTAL ANCILLARY	776,400.00	86,368.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	776,400.00	86,368.00

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,496.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,361.00	CONTRACTUAL ALLOW	6,041.03
NON-COVERD CHARGES	135.00	TOTAL MEDICAID LIAB	1,319.97
		LESS: COB	1,307.96
		LESS: COPAYMENT	12.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181.00	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	1,470.00	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	1,513.00	135.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,159.00	0.00	SPECIAL SERVICES	0.00	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	7,361.00	135.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,361.00	135.00

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: 09/24/2013  
Run Time: 14:31:26  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,855,892.20	ADJUSTMENTS	121,453.69
COVERED CHARGES	2,625,110.00	CONTRACTUAL ALLOW	2,152,304.99
NON-COVERD CHARGES	230,782.20	TOTAL MEDICAID LIAB	472,805.01
		LESS: COB	0.00
		LESS: COPAYMENT	732.16
		REIMBURSEMENT	472,072.85

TOTAL NUMBER OF CLAIMS 92

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143,592.00	7,436.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,722.00	76.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,938.00	1,734.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,995.00	12,292.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	629.00	FEE SCHEDULE LAB	54,270.00	12,546.20
EKG/ECG	2,730.00	273.00	MRI SERVICES	0.00	0.00
IV THERAPY	55,026.00	2,902.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	127,515.00	5.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,503.00	60.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,572.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,492.00	535.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,726.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,720,240.00	170,808.00
RADIOLOGY THERAPEUTIC	90,869.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	189.00	TRAUMA RESPONSE	0.00	2,874.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,402.00	3,254.00
LITHOTRIPSY	140,000.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,765.00	7,310.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,641.00	5,035.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,564.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,766.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,346.00	260.00			
			TOTAL ANCILLARY	2,625,110.00	230,782.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,625,110.00	230,782.20



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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:31:41  
 Page: 1

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	620,945.07	ADJUSTMENTS	24,710.60
COVERED CHARGES	567,751.67	CONTRACTUAL ALLOW	311,658.44
NON-COVERD CHARGES	53,193.40	TOTAL MEDICAID LIAB	256,093.23
		LESS: COB	466.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	255,627.23

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	117		0	61,782.00		44,162.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	117		0	61,782.00		44,162.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	45		0	74,235.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	45		0	74,235.00		0.00
TOTAL ACCOMODATIONS	162		0	136,017.00		44,162.00

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,857.05	0.00	OTHER LAB	778.00	0.00
MED/SURG SUPPLY	46,476.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	111,494.28	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,182.00	0.00	OTHER THERAPEUTIC SVC	68.00	0.00
CT SCAN	47,619.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,444.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,791.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,635.25	4,497.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,898.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,372.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,802.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,302.05	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	761.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,149.74	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	644.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	203.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	12.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,888.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,498.00	4,522.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,555.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	316.30	0.00			
			TOTAL ANCILLARY	431,734.67	9,031.40
			TOTAL ACCOMODATIONS	136,017.00	44,162.00
			TOTAL CHARGES	567,751.67	53,193.40

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

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

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 14:31:46  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,113,268.48	ADJUSTMENTS	44,502.44
COVERED CHARGES	1,776,130.06	CONTRACTUAL ALLOW	1,190,032.38
NON-COVERD CHARGES	337,138.42	TOTAL MEDICAID LIAB	586,097.68
		LESS: COB	0.00
		LESS: COPAYMENT	1,581.00
		REIMBURSEMENT	584,516.68
		ALL OTHER	556,097.44
		FEE SCHEDULE-LAB	28,056.51
		INJECTABLE DRUGS	362.73

TOTAL NUMBER OF CLAIMS 1,265

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

PROVIDER NUMBER  
 000000316A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,053.61	1,590.09	OTHER LAB	2,237.00	389.00
MED/SURG SUPPLY	118,129.85	247.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,738.00	EDUCATION & TRAINING	98.00	0.00
RADIOLOGY-DIAGNOSTIC	95,363.00	3,279.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	128,133.00	84,943.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,757.00	5,369.00	FEE SCHEDULE LAB	341,180.52	78,017.00
EKG/ECG	25,194.00	6,235.00	MRI SERVICES	29,751.00	0.00
IV THERAPY	26,966.97	16,484.77	PROFESSIONAL FEES	0.00	2,023.00
OPERATING ROOM	274,861.00	79,675.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,987.00	3,501.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	126,490.00	35,782.50	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	345,615.40	4,806.33	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	97,408.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,082.76	271.18
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	680.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	52.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,882.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	54.00
OTHER IMAGING SERVICE	27,530.00	6,706.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,915.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,718.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,594.66	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,063.79	1,313.05			
			TOTAL ANCILLARY	1,776,130.06	336,038.42
			TOTAL ACCOMODATIONS	0.00	1,100.00
			TOTAL CHARGES	1,776,130.06	337,138.42

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

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

Run Date: 09/24/2013  
Run Time: 14:31:46  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
454	2212272004566	07/19/12 - 07/19/12	10/01/12	0.00	54.00	0.00	0.00	0.00
TOTAL				0.00	54.00	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: 09/24/2013  
Run Time: 14:32:38  
Page: 7

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,745.47	ADJUSTMENTS	0.00
COVERED CHARGES	1,745.47	CONTRACTUAL ALLOW	934.14
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	811.33
		LESS: COB	811.33
		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

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

PROVIDER NUMBER  
 000000316A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140.62	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	194.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	138.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,265.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,745.47	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,745.47	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: 09/24/2013  
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Page: 9

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

PROVIDER NUMBER  
000000316A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	187,385.66	ADJUSTMENTS	617.00
COVERED CHARGES	170,523.95	CONTRACTUAL ALLOW	160,423.95
NON-COVERD CHARGES	16,861.71	TOTAL MEDICAID LIAB	10,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	417.00
		REIMBURSEMENT	9,683.00
		TOTAL NUMBER OF CLAIMS	202

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,069.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,612.00	100.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	89.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,904.00	583.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,658.00	9,135.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	355.00	FEE SCHEDULE LAB	27,671.00	3,634.00
EKG/ECG	2,639.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,911.63	639.86	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,143.00	486.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	105,066.69	1,762.55	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	103.94	36.80
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	1,659.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	86.00	40.50			
			TOTAL ANCILLARY	170,523.95	16,861.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	170,523.95	16,861.71

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

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

Run Date: 09/24/2013  
Run Time: 14:32:44  
Page: 11

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

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	465.03	ADJUSTMENTS	0.00
COVERED CHARGES	465.03	CONTRACTUAL ALLOW	294.15
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	170.88
		LESS: COB	170.88
		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: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000316A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	450.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	465.03	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	465.03	0.00

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000316A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,337.95	ADJUSTMENTS	0.00
COVERED CHARGES	9,770.95	CONTRACTUAL ALLOW	5,297.29
NON-COVERD CHARGES	567.00	TOTAL MEDICAID LIAB	4,473.66
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,470.66

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	199.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,140.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	423.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	51.00	44.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,224.00	100.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	761.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,395.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,770.95	567.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,770.95	567.00

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000316A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,626,676.04	ADJUSTMENTS	1,791,551.98
COVERED CHARGES	31,016,561.00	CONTRACTUAL ALLOW	22,575,858.10
NON-COVERD CHARGES	610,115.04	TOTAL MEDICAID LIAB	8,440,702.90
		LESS: COB	125,334.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,315,368.13

TOTAL NUMBER OF ADMISSIONS 865

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,940		0	3,405,509.00		21,580.00
ROUTINE NURSERY	375		0	360,000.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,315		0	3,765,509.00		21,580.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,779		0	3,276,150.00		23,480.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,779		0	3,276,150.00		23,480.00
TOTAL ACCOMODATIONS	6,094		0	7,041,659.00		45,060.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,526,123.00	4,712.00	OTHER LAB	90,547.00	0.00
MED/SURG SUPPLY	1,206,804.00	22,568.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,100,727.00	21,625.00	EDUCATION & TRAINING	292.00	0.00
RADIOLOGY-DIAGNOSTIC	1,074,897.00	3,151.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	982,201.00	48,499.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	272,922.00	1,792.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	78,257.00	0.00	MRI SERVICES	279,877.00	0.00
IV THERAPY	224,277.00	8,290.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,953,887.00	34,593.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	449,271.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,529,781.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	522,399.00	2,356.00	AMBULANCE	0.00	0.00
GI SERVICES	146,704.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	535,682.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	239,432.00	2,742.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	141,385.00	0.00	INJECTABLE DRUGS	5,287,716.00	12,186.00
RADIOLOGY THERAPEUTIC	126,912.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	99,769.00	561.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	95,473.00	351.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	150,201.00	32,586.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	151.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	154,177.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	176,043.00	14,014.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	988,752.00	270,259.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	79,135.00	84,770.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	148,867.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,112.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	289,129.00	0.00			
			TOTAL ANCILLARY	23,974,902.00	565,055.04
			TOTAL ACCOMODATIONS	7,041,659.00	45,060.00
			TOTAL CHARGES	31,016,561.00	610,115.04

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

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

Run Date: 09/24/2013  
 Run Time: 14:33:43  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	479,455.70	ADJUSTMENTS	0.00
COVERED CHARGES	478,980.00	CONTRACTUAL ALLOW	419,513.58
NON-COVERD CHARGES	475.70	TOTAL MEDICAID LIAB	59,466.42
		LESS: COB	59,466.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32		0	27,680.00		0.00
ROUTINE NURSERY	10		0	14,540.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	42		0	42,220.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	83		0	97,442.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	83		0	97,442.00		0.00
TOTAL ACCOMODATIONS	125		0	139,662.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CANDLER HOSPITAL  
 5353 REYNOLDS ST  
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,126.00	0.00	OTHER LAB	1,026.00	0.00
MED/SURG SUPPLY	8,935.00	475.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,356.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,388.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,127.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,775.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,386.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,829.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,265.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,605.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,963.00	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	1,192.00	0.00	INJECTABLE DRUGS	84,288.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,307.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	681.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,439.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	339,318.00	475.70
			TOTAL ACCOMODATIONS	139,662.00	0.00
			TOTAL CHARGES	478,980.00	475.70

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,018,819.90	ADJUSTMENTS	731,426.59
COVERED CHARGES	13,969,015.40	CONTRACTUAL ALLOW	11,027,280.72
NON-COVERD CHARGES	1,049,804.50	TOTAL MEDICAID LIAB	2,941,734.68
		LESS: COB	21,554.49
		LESS: COPAYMENT	8,244.93
		REIMBURSEMENT	2,911,935.26
		ALL OTHER	2,251,247.96
		FEE SCHEDULE-LAB	401,807.87
		INJECTABLE DRUGS	258,879.43
		TOTAL NUMBER OF CLAIMS	8,052

CANDLER HOSPITAL  
 5353 REYNOLDS ST  
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	671,425.00	62,305.00	OTHER LAB	67,354.00	1,804.00
MED/SURG SUPPLY	602,839.00	512.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	15.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	693,803.00	43,774.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,190,325.00	43,941.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	74,664.00	31,507.00	FEE SCHEDULE LAB	2,451,776.40	315,073.50
EKG/ECG	69,976.00	504.00	MRI SERVICES	167,154.00	14,871.00
IV THERAPY	736,308.00	25,553.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,555,466.00	143,876.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	102,992.00	1,078.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108,495.00	8,901.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	373,961.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	58,425.00	1,384.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,560,187.00	1,184.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	378,534.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,254,338.00	105,860.00
RADIOLOGY THERAPEUTIC	255,757.00	54,131.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,062.00	14,799.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,863.00	5,627.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,000.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,900.00	3,522.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	81,455.00	0.00
LITHOTRIPSY	36,350.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	713,014.00	66,785.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	206,429.00	82,579.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,057.00	1,129.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	44,695.00	7,469.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	101,418.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	288,993.00	8,621.00			
			TOTAL ANCILLARY	13,969,015.40	1,049,804.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,969,015.40	1,049,804.50

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

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	330,113.00	ADJUSTMENTS	0.00
COVERED CHARGES	228,702.40	CONTRACTUAL ALLOW	142,327.32
NON-COVERD CHARGES	101,410.60	TOTAL MEDICAID LIAB	86,375.08
		LESS: COB	86,171.61
		LESS: COPAYMENT	203.47
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 129

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

CANDLER HOSPITAL  
 5353 REYNOLDS ST  
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,038.00	31,055.00	OTHER LAB	1,504.00	859.00
MED/SURG SUPPLY	10,540.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,609.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,642.00	8,922.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,140.00	0.00	FEE SCHEDULE LAB	43,790.00	4,727.00
EKG/ECG	504.00	0.00	MRI SERVICES	0.00	1,801.00
IV THERAPY	22,208.00	358.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,108.40	16,927.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,972.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	690.00	24,304.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,332.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,768.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,022.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,078.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,895.00	468.00
RADIOLOGY THERAPEUTIC	4,233.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	783.00	691.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	336.00	908.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	258.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,124.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,244.00	3,172.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,362.00	4,242.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,290.00	208.00			
			TOTAL ANCILLARY	228,702.40	101,410.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	228,702.40	101,410.60



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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	793,875.00	ADJUSTMENTS	3,744.66
COVERED CHARGES	769,245.00	CONTRACTUAL ALLOW	727,600.74
NON-COVERD CHARGES	24,630.00	TOTAL MEDICAID LIAB	41,644.26
		LESS: COB	125.55
		LESS: COPAYMENT	1,398.08
		REIMBURSEMENT	40,120.63
		TOTAL NUMBER OF CLAIMS	745

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,151.00	1,372.00	OTHER LAB	6,093.00	2,255.00
MED/SURG SUPPLY	2,234.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,512.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,018.00	5,245.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	115,959.00	6,515.00
EKG/ECG	5,166.00	0.00	MRI SERVICES	3,330.00	1,627.00
IV THERAPY	40,453.00	1,186.00	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	4,356.00	396.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	397,734.00	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	28,960.00	1,196.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,275.00	4,838.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,129.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	963.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	912.00	0.00			
			TOTAL ANCILLARY	769,245.00	24,630.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	769,245.00	24,630.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,143.00	ADJUSTMENTS	0.00
COVERED CHARGES	16,483.00	CONTRACTUAL ALLOW	12,032.13
NON-COVERD CHARGES	1,660.00	TOTAL MEDICAID LIAB	4,450.87
		LESS: COB	4,444.87
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.00	409.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	393.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,476.00	743.00
EKG/ECG	126.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	557.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	9,745.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	416.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,630.00	508.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,483.00	1,660.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,483.00	1,660.00

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

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,176,924.00	ADJUSTMENTS	162,857.92
COVERED CHARGES	4,126,527.00	CONTRACTUAL ALLOW	3,615,534.75
NON-COVERD CHARGES	50,397.00	TOTAL MEDICAID LIAB	510,992.25
		LESS: COB	816.00
		LESS: COPAYMENT	1,674.38
		REIMBURSEMENT	508,501.87
		TOTAL NUMBER OF CLAIMS	100

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	223,933.00	1,675.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66,790.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,129.00	353.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,829.00	2,693.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,592.00	6,220.00
EKG/ECG	630.00	0.00	MRI SERVICES	4,900.00	0.00
IV THERAPY	413,299.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	152,497.20	9,126.00	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	44,117.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,872.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,896.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,765,230.00	4,845.00
RADIOLOGY THERAPEUTIC	1,322,183.00	23,890.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	45,158.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	55.00
OTHER IMAGING SERVICE	735.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,344.00	1,540.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,978.00	0.00			
			TOTAL ANCILLARY	4,126,527.00	50,397.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,126,527.00	50,397.00

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

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3000	2212235014104	02/17/12 - 02/17/12	08/27/12	0.00	55.00	0.00	0.00	0.00
TOTAL				0.00	55.00	0.00	0.00	0.00

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHARLTON MEMORIAL HOSPITAL  
 2449 THIRD ST  
 FOLKSTON,GA 31537-8919

PROVIDER NUMBER 000000338A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,409.94	ADJUSTMENTS	22,779.74
COVERED CHARGES	65,089.94	CONTRACTUAL ALLOW	-4,884.81
NON-COVERD CHARGES	320.00	TOTAL MEDICAID LIAB	69,974.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	69,974.75

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	39		0	21,216.00		320.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	39		0	21,216.00		320.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	39		0	21,216.00		320.00

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

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

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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHARLTON MEMORIAL HOSPITAL  
 2449 THIRD ST  
 FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,663.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	165.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,324.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,228.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	264.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,344.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,324.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	742.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	133.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	686.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	43,873.94	0.00
			TOTAL ACCOMODATIONS	21,216.00	320.00
			TOTAL CHARGES	65,089.94	320.00

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

CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	645,089.07	ADJUSTMENTS	69,094.16
COVERED CHARGES	523,241.99	CONTRACTUAL ALLOW	329,173.57
NON-COVERD CHARGES	121,847.08	TOTAL MEDICAID LIAB	194,068.42
		LESS: COB	43.98
		LESS: COPAYMENT	1,212.00
		REIMBURSEMENT	192,812.44
		ALL OTHER	162,932.31
		FEE SCHEDULE-LAB	24,967.52
		INJECTABLE DRUGS	4,912.61

TOTAL NUMBER OF CLAIMS 736

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

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

Run Date: 09/24/2013  
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CHARLTON MEMORIAL HOSPITAL  
 2449 THIRD ST  
 FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,225.87	76.00	OTHER LAB	4,209.00	594.00
MED/SURG SUPPLY	891.50	11.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	269.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,481.50	1,061.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,214.00	7,099.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	462.00	14,823.00	FEE SCHEDULE LAB	188,842.10	68,611.80
EKG/ECG	4,958.63	1,120.00	MRI SERVICES	30,118.00	1,857.00
IV THERAPY	10,765.00	672.00	PROFESSIONAL FEES	0.00	2,793.00
OPERATING ROOM	10,525.00	400.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,144.00	13,896.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	310.52	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	116,499.00	3,019.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,847.87	2,192.16
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	758.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,200.00	1,938.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,643.00	228.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	409.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,554.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	942.00	429.12			
			TOTAL ANCILLARY	523,241.99	121,847.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	523,241.99	121,847.08

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,368.61	ADJUSTMENTS	191.00
COVERED CHARGES	23,716.61	CONTRACTUAL ALLOW	21,516.61
NON-COVERD CHARGES	652.00	TOTAL MEDICAID LIAB	2,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	2,113.00
		TOTAL NUMBER OF CLAIMS	44

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEMORIAL HOSPITAL  
 2449 THIRD ST  
 FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	89.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	71.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,949.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,906.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,857.00	509.00
EKG/ECG	336.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	452.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	465.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,907.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	375.41	72.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,716.61	652.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,716.61	652.00



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: 09/24/2013  
Run Time: 14:38:38  
Page: 9

CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 14:38:38  
Page: 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,494.17	ADJUSTMENTS	4,430.06
COVERED CHARGES	36,075.17	CONTRACTUAL ALLOW	27,209.05
NON-COVERD CHARGES	3,419.00	TOTAL MEDICAID LIAB	8,866.12
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	8,860.12
		TOTAL NUMBER OF CLAIMS	2

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

CHARLTON MEMORIAL HOSPITAL  
 2449 THIRD ST  
 FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,734.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	100.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	117.00	FEE SCHEDULE LAB	3,346.00	3,078.00
EKG/ECG	112.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112.00	224.00	FREE STANDING CLINIC	0.00	0.00
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	7,671.05	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	36,075.17	3,419.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,075.17	3,419.00

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: 09/24/2013  
Run Time: 14:38:38  
Page: 12

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:38:46  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,455,977.93	ADJUSTMENTS	2,786,608.82
COVERED CHARGES	50,594,576.78	CONTRACTUAL ALLOW	35,403,297.50
NON-COVERD CHARGES	1,861,401.15	TOTAL MEDICAID LIAB	15,191,279.28
		LESS: COB	75,416.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,115,863.24

TOTAL NUMBER OF ADMISSIONS 2,199

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,427		0	6,222,977.00		478,940.00
ROUTINE NURSERY	1,417		0	1,774,279.00		65,372.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,844		0	7,997,256.00		544,312.00
SPECIAL CARE SERVICES						
CCU	153		0	143,973.00		0.00
ICU	1,611		0	3,803,103.00		0.00
NICU	375		0	1,082,580.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		30	0.00		41,460.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,139		30	5,029,656.00		41,460.00
TOTAL ACCOMODATIONS	10,983		30	13,026,912.00		585,772.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,710,223.08	196,689.64	OTHER LAB	394,870.09	3,960.24
MED/SURG SUPPLY	2,518,588.17	63,883.15	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,663,393.30	157,718.50	EDUCATION & TRAINING	54,155.78	469.24
RADIOLOGY-DIAGNOSTIC	751,271.41	9,518.41	OTHER THERAPEUTIC SVC	722.02	8,399.39
CT SCAN	1,479,202.99	444,476.07	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	222,963.98	17,183.07	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	296,068.55	684.63	MRI SERVICES	1,105,403.13	0.00
IV THERAPY	609,147.63	19,990.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,802,207.55	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,035,282.29	0.00	REHAB THERAPY	967.88	0.00
RESPIRATORY SERVICES	2,948,689.26	62,009.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	650,488.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	427,007.19	5,642.04	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,642,348.96	4,931.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	464,506.08	453.65	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	342,048.52	6,621.04	INJECTABLE DRUGS	19,292.77	17,074.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	81,536.44	10,152.74	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	131,485.38	13,741.37	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	255,598.74	60,180.38	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	403.78	4,546.26	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	613,362.24	2,344.57
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	515,590.33	3,276.38			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	678,596.44	20,519.27			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	378,414.31	102,538.52			
AUDIOLOGY	499,985.00	887.57			
CARDIOLOGY	1,836,788.33	8,747.57			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,742.21	759.58			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	404,312.66	28,229.00			
			TOTAL ANCILLARY	37,567,664.78	1,275,629.15
			TOTAL ACCOMODATIONS	13,026,912.00	585,772.00
			TOTAL CHARGES	50,594,576.78	1,861,401.15

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,811.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,610.00	CONTRACTUAL ALLOW	78.70
NON-COVERD CHARGES	201.00	TOTAL MEDICAID LIAB	10,531.30
		LESS: COB	10,531.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	2,715.00		201.00
ROUTINE NURSERY	0		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	2,715.00		201.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	2,715.00		201.00

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

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

Run Date: 09/24/2013  
 Run Time: 14:40:06  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	641.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	449.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,065.14	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,738.92	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,895.00	0.00
			TOTAL ACCOMODATIONS	2,715.00	201.00
			TOTAL CHARGES	10,610.00	201.00



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: 09/24/2013  
Run Time: 14:40:09  
Page: 5

SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW 6TH FL  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,152,053.65	ADJUSTMENTS	710,375.82
COVERED CHARGES	20,398,633.73	CONTRACTUAL ALLOW	16,046,588.44
NON-COVERD CHARGES	2,753,419.92	TOTAL MEDICAID LIAB	4,352,045.29
		LESS: COB	5,068.54
		LESS: COPAYMENT	4,752.93
		REIMBURSEMENT	4,342,223.82
		ALL OTHER	3,725,859.78
		FEE SCHEDULE-LAB	392,816.77
		INJECTABLE DRUGS	223,547.27

TOTAL NUMBER OF CLAIMS 9,287

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322,741.60	3,914.68	OTHER LAB	286,260.46	0.00
MED/SURG SUPPLY	862,384.16	8,904.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	51.05	EDUCATION & TRAINING	166.75	1,444.73
RADIOLOGY-DIAGNOSTIC	869,555.55	18,397.13	OTHER THERAPEUTIC SVC	0.00	7,521.03
CT SCAN	1,721,258.56	194,344.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	39,876.03	19,513.05	FEE SCHEDULE LAB	3,492,608.89	628,861.06
EKG/ECG	199,096.40	7,346.55	MRI SERVICES	579,785.92	52,843.59
IV THERAPY	802,478.68	81,913.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	946,400.88	372,114.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	210,805.74	1,261.54	REHAB THERAPY	0.00	234.92
RESPIRATORY SERVICES	100,917.83	3,139.12	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	491,803.76	14,496.71	AMBULANCE	0.00	0.00
GI SERVICES	427,209.18	101,484.27	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,814,731.21	38,875.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	396,294.41	799.73	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,065,370.70	354,968.24
RADIOLOGY THERAPEUTIC	29,662.96	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,061.44	27,685.92	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,541.01	23,685.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,013.94	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	278,553.15	7,201.88	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	136,386.87	75,385.22
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	26.77
OTHER IMAGING SERVICE	1,294,949.50	241,120.54			
BLOOD	4,068.11	0.00			
BLOOD STORAGE & PRO.	39,784.63	7,308.40			
ONCOLOGY	6,266.48	0.00			
NUCLEAR MEDICINE	245,493.68	109,611.27			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	308,370.05	332,916.83			
AMBULATORY SURGERY	14,232.44	736.90			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,007.56	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	385,509.14	4,245.11			
			TOTAL ANCILLARY	20,398,633.73	2,753,367.56
			TOTAL ACCOMODATIONS	0.00	52.36
			TOTAL CHARGES	20,398,633.73	2,753,419.92

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

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

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SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW 6TH FL  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212233006239	07/21/11 - 07/21/11	08/27/12	0.00	26.77	0.00	0.00	0.00
TOTAL				0.00	26.77	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: 09/24/2013  
Run Time: 14:43:01  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW 6TH FL  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,575.03	ADJUSTMENTS	0.00
COVERED CHARGES	82,235.98	CONTRACTUAL ALLOW	13,359.96
NON-COVERD CHARGES	20,339.05	TOTAL MEDICAID LIAB	68,876.02
		LESS: COB	68,843.26
		LESS: COPAYMENT	32.76
		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

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,352.73	0.00	OTHER LAB	2,230.81	0.00
MED/SURG SUPPLY	6,909.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	155.05	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,415.27	110.04	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,772.73	5,321.58	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,700.89	748.51
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,983.65	166.03	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,646.74	3,092.23	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,600.71	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	993.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,681.73	754.43	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,001.32	156.63	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,827.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,286.79	809.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,552.34	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	821.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,842.18	2,346.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,615.65	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	6,679.12			
			TOTAL ANCILLARY	82,235.98	20,339.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	82,235.98	20,339.05

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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SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW 6TH FL  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,707,034.67	ADJUSTMENTS	3,024.61
COVERED CHARGES	1,621,544.98	CONTRACTUAL ALLOW	1,539,816.65
NON-COVERD CHARGES	85,489.69	TOTAL MEDICAID LIAB	81,728.33
		LESS: COB	0.00
		LESS: COPAYMENT	2,421.13
		REIMBURSEMENT	79,307.20
		TOTAL NUMBER OF CLAIMS	1,461

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,103.96	207.15	OTHER LAB	8,896.24	0.00
MED/SURG SUPPLY	23,049.18	822.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,397.75	636.02	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,983.15	15,535.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	293,994.70	40,866.42
EKG/ECG	17,111.29	0.00	MRI SERVICES	3,730.97	0.00
IV THERAPY	46,462.27	1,970.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,367.21	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,006.74	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,720.48	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,835.24	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	934,770.73	1,440.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,292.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,666.16	7,189.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	397.60	340.96	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,715.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	70,031.75	16,317.99			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,295.42	162.76			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	717.02	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,621,544.98	85,489.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,621,544.98	85,489.69

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

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

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SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW 6TH FL  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,588.15	ADJUSTMENTS	0.00
COVERED CHARGES	9,234.41	CONTRACTUAL ALLOW	57.19
NON-COVERD CHARGES	1,353.74	TOTAL MEDICAID LIAB	9,177.22
		LESS: COB	9,177.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6



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

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	212.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	296.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,126.59	227.70
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	444.32	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,272.80	313.26	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	95.11	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	704.27	812.78			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,234.41	1,353.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,234.41	1,353.74

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

SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW 6TH FL  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,434,569.12	ADJUSTMENTS	100,109.56
COVERED CHARGES	2,100,989.83	CONTRACTUAL ALLOW	1,746,821.85
NON-COVERD CHARGES	333,579.29	TOTAL MEDICAID LIAB	354,167.98
		LESS: COB	18,544.88
		LESS: COPAYMENT	338.54
		REIMBURSEMENT	335,284.56
		TOTAL NUMBER OF CLAIMS	67

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

SOUTHERN REGIONAL MEDICAL CENTER  
 11 UPPER RIVERDALE RD SW 6TH FL  
 RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,497.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	119,647.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,859.18	5,113.76	OTHER THERAPEUTIC SVC	0.00	758.96
CT SCAN	3,961.04	1,616.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	64,362.61	12,374.35
EKG/ECG	3,449.49	1,628.20	MRI SERVICES	0.00	0.00
IV THERAPY	58,760.17	4,657.35	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	269,658.40	49,782.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,096.42	174.91	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,930.11	3,270.10	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,347.14	75.37	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	48,251.93	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	839,310.60	152,152.01
RADIOLOGY THERAPEUTIC	11,304.07	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,861.46	146.47	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	421,308.66	0.00
LITHOTRIPSY	37,325.35	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,452.65	2,300.31			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,248.89	0.00			
ONCOLOGY	569.68	0.00			
NUCLEAR MEDICINE	11,665.66	3,572.78			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,692.37	95,954.99			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,428.40	0.00			
			TOTAL ANCILLARY	2,100,989.83	333,579.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,100,989.83	333,579.29

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

SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW 6TH FL  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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

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

PROVIDER NUMBER 000000415A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,779.36	ADJUSTMENTS	0.00
COVERED CHARGES	114,748.36	CONTRACTUAL ALLOW	37,818.28
NON-COVERD CHARGES	31.00	TOTAL MEDICAID LIAB	76,930.08
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	76,930.08

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	38		0	11,096.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	38		0	11,096.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	38		0	11,096.00		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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,018.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,884.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,149.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,553.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	184.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,179.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,275.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,074.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	31.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	334.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,246.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	590.00	0.00			
			TOTAL ANCILLARY	103,652.36	31.00
			TOTAL ACCOMODATIONS	11,096.00	0.00
			TOTAL CHARGES	114,748.36	31.00

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	609,944.56	ADJUSTMENTS	13,821.36
COVERED CHARGES	550,053.56	CONTRACTUAL ALLOW	209,427.78
NON-COVERD CHARGES	59,891.00	TOTAL MEDICAID LIAB	340,625.78
		LESS: COB	0.00
		LESS: COPAYMENT	1,392.00
		REIMBURSEMENT	339,233.78
		ALL OTHER	316,594.86
		FEE SCHEDULE-LAB	22,638.92
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 981



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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,346.51	0.00	OTHER LAB	1,746.00	0.00
MED/SURG SUPPLY	17,332.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,633.00	117.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,014.50	5,630.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,128.00	678.00	FEE SCHEDULE LAB	164,426.50	48,325.00
EKG/ECG	14,504.00	0.00	MRI SERVICES	2,700.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,669.50
OPERATING ROOM	7,493.00	1,006.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,486.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	91,301.00	2,101.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,170.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	324.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53.00
OTHER IMAGING SERVICE	10,923.00	274.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,498.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	77,180.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,727.00	37.00			
			TOTAL ANCILLARY	550,053.56	59,891.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	550,053.56	59,891.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012151038994	05/21/12 - 05/21/12	06/04/12	0.00	53.00	0.00	0.00	0.00
TOTAL				0.00	53.00	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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 14:44:11  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,238.67	ADJUSTMENTS	158.82
COVERED CHARGES	50,547.67	CONTRACTUAL ALLOW	39,455.31
NON-COVERD CHARGES	691.00	TOTAL MEDICAID LIAB	11,092.36
		LESS: COB	0.00
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	10,729.36
		TOTAL NUMBER OF CLAIMS	199

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,306.80	0.00	OTHER LAB	214.00	0.00
MED/SURG SUPPLY	1,014.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,580.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,086.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,326.00	572.00
EKG/ECG	1,204.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	74.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	281.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,535.00	45.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	50,547.67	691.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,547.67	691.00

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: 09/24/2013  
Run Time: 14:44:18  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 14:44:18  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:44:25  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,976,586.87	ADJUSTMENTS	4,784,298.62
COVERED CHARGES	68,396,644.81	CONTRACTUAL ALLOW	48,705,530.56
NON-COVERD CHARGES	3,579,942.06	TOTAL MEDICAID LIAB	19,691,114.25
		LESS: COB	120,135.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,570,978.54
		TOTAL NUMBER OF ADMISSIONS	2,781

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,140		35	7,164,160.00		2,278,272.00
ROUTINE NURSERY	1,266		0	551,649.00		68,670.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		40,492.75
TOTAL ROUTINE	8,406		35	7,715,809.00		2,387,434.75
SPECIAL CARE SERVICES						
CCU	2,447		14	3,458,180.00		46,386.00
ICU	1,007		0	2,123,649.00		0.00
NICU	1,917		0	4,596,314.50		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		216	0.00		290,304.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,371		230	10,178,143.50		336,690.00
TOTAL ACCOMODATIONS	13,777		265	17,893,952.50		2,724,124.75

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,549,526.38	83,986.58	OTHER LAB	552,306.00	0.00
MED/SURG SUPPLY	2,350,165.34	34,386.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,088,730.00	23,233.00	EDUCATION & TRAINING	52,741.00	0.00
RADIOLOGY-DIAGNOSTIC	1,311,872.00	3,682.00	OTHER THERAPEUTIC SVC	0.00	2,561.00
CT SCAN	2,620,055.00	16,697.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	328,894.00	8,241.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	354,116.00	807.00	MRI SERVICES	847,933.00	0.00
IV THERAPY	596,090.00	80,442.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,895,227.00	24,348.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,613,082.00	7,975.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,162,416.00	6,386.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	907,076.00	4,893.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,963,412.00	4,293.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	729,013.00	1,501.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	320,167.00	6,446.00	INJECTABLE DRUGS	66,076.50	0.00
RADIOLOGY THERAPEUTIC	20,485.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	183,973.00	5,736.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	108,704.00	388.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,008,444.00	275,589.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,582.00	8,890.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	72,693.00	8,738.00	IMPL DEV CHARGE PATIENTS	1,499,792.65	3,734.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	21,373.00
OTHER IMAGING SERVICE	473,032.00	4,229.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	403,518.00	139,016.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	568,675.00	45,260.00			
AUDIOLOGY	270,661.00	608.00			
CARDIOLOGY	2,271,351.00	7,020.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	124,513.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	151,370.44	25,358.00			
			TOTAL ANCILLARY	50,502,692.31	855,817.31
			TOTAL ACCOMODATIONS	17,893,952.50	2,724,124.75
			TOTAL CHARGES	68,396,644.81	3,579,942.06

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

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

Run Date: 09/24/2013  
 Run Time: 14:44:25  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012167069439	06/01/12 - 06/07/12	06/25/12	0.00	194.00	0.00	0.00	0.00
615	2312180000202	03/06/12 - 04/03/12	10/01/12	0.00	2,947.00	0.00	0.00	0.00
905	5912248000546	03/10/12 - 03/13/12	09/10/12	0.00	776.00	0.00	0.00	0.00
615	2012275031260	12/05/11 - 12/15/11	10/08/12	0.00	2,947.00	0.00	0.00	0.00
-1	2312298000106	06/18/12 - 06/23/12	12/03/12	0.00	0.00	0.00	0.00	0.00
615	2312324000005	03/01/12 - 04/02/12	12/17/12	0.00	5,781.00	0.00	0.00	0.00
615	2013009045273	04/25/12 - 05/14/12	01/14/13	0.00	2,947.00	0.00	0.00	0.00
615	9713046964027	08/22/11 - 09/02/11	03/04/13	0.00	5,781.00	0.00	0.00	0.00
TOTAL				0.00	21,373.00	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: 09/24/2013  
 Run Time: 14:46:50  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	436,990.22	ADJUSTMENTS	0.00
COVERED CHARGES	423,575.22	CONTRACTUAL ALLOW	152,325.07
NON-COVERD CHARGES	13,415.00	TOTAL MEDICAID LIAB	271,250.15
		LESS: COB	271,250.15
		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	42		0	42,588.00		816.00
ROUTINE NURSERY	8		0	2,664.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	50		0	45,252.00		816.00
SPECIAL CARE SERVICES						
CCU	3		0	4,326.00		0.00
ICU	19		0	36,747.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	22		0	41,073.00		0.00
TOTAL ACCOMODATIONS	72		0	86,325.00		816.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,019.04	1,645.00	OTHER LAB	671.00	0.00
MED/SURG SUPPLY	12,548.00	368.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	50,571.00	0.00	EDUCATION & TRAINING	1,539.00	0.00
RADIOLOGY-DIAGNOSTIC	2,421.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,542.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	249.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,614.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,314.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	101,932.00	9,730.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,327.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,499.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,399.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,686.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,008.00	0.00	INJECTABLE DRUGS	393.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,975.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	216.00	144.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	746.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,557.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,794.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,456.00	364.00			
CARDIOLOGY	3,636.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,390.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	748.18	348.00			
			TOTAL ANCILLARY	337,250.22	12,599.00
			TOTAL ACCOMODATIONS	86,325.00	816.00
			TOTAL CHARGES	423,575.22	13,415.00

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 COBB HOSPITAL  
3950 AUSTELL RD  
AUSTELL,GA 30106-1121

PROVIDER NUMBER  
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,013,810.16	ADJUSTMENTS	1,414,794.94
COVERED CHARGES	24,797,975.30	CONTRACTUAL ALLOW	19,855,320.05
NON-COVERD CHARGES	2,215,834.86	TOTAL MEDICAID LIAB	4,942,655.25
		LESS: COB	22,160.21
		LESS: COPAYMENT	9,631.85
		REIMBURSEMENT	4,910,863.19
		ALL OTHER	4,422,630.27
		FEE SCHEDULE-LAB	317,565.64
		INJECTABLE DRUGS	170,667.28

TOTAL NUMBER OF CLAIMS 10,132

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,000,102.51	4,916.25	OTHER LAB	173,626.00	5,599.00
MED/SURG SUPPLY	524,497.97	1,601.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	58.00	EDUCATION & TRAINING	7,238.00	10,687.00
RADIOLOGY-DIAGNOSTIC	1,187,192.00	29,868.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,950,551.00	387,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	87,601.00	74,755.00	FEE SCHEDULE LAB	4,067,912.33	509,195.44
EKG/ECG	329,091.00	3,820.00	MRI SERVICES	554,820.00	120,622.00
IV THERAPY	877,128.00	1,203.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,656,055.00	349,640.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	369,260.00	741.00	REHAB THERAPY	4,405.00	150.00
RESPIRATORY SERVICES	219,528.00	48,730.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	756,362.00	13,767.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,333,389.00	13,605.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	599,598.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	824,786.25	227,338.25
RADIOLOGY THERAPEUTIC	139,455.00	1,539.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,415.00	25,020.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,877.00	13,455.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	154,143.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	236,124.00	17,446.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	189,617.00	4,803.00	IMPL DEV CHARGE PATIENTS	182,345.95	9,666.92
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	194.00
OTHER IMAGING SERVICE	689,711.00	36,324.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69,568.00	12,076.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	513,176.00	4,653.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	516,723.00	131,814.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,330.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	681,490.29	1,004.00			
			TOTAL ANCILLARY	24,797,975.30	2,215,834.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,797,975.30	2,215,834.86

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

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

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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5912165000067	04/30/12 - 04/30/12	06/18/12	0.00	194.00	0.00	0.00	0.00
TOTAL				0.00	194.00	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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	543,799.75	ADJUSTMENTS	0.00
COVERED CHARGES	461,883.25	CONTRACTUAL ALLOW	90,476.70
NON-COVERD CHARGES	81,916.50	TOTAL MEDICAID LIAB	371,406.55
		LESS: COB	371,282.59
		LESS: COPAYMENT	123.96
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 225

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,765.25	0.00	OTHER LAB	4,321.00	903.00
MED/SURG SUPPLY	9,039.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	454.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,374.00	399.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,548.00	28,655.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	80,167.20	8,530.50
EKG/ECG	4,627.00	0.00	MRI SERVICES	3,527.00	0.00
IV THERAPY	16,721.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,572.00	9,828.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,352.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,210.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,657.00	15,850.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,099.00	174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,007.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,424.00	789.00
RADIOLOGY THERAPEUTIC	1,288.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,774.00	251.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	659.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,697.00	3,593.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,371.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,199.00	12,490.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,484.80	0.00			
			TOTAL ANCILLARY	461,883.25	81,916.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	461,883.25	81,916.50

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,258,030.31	ADJUSTMENTS	5,392.12
COVERED CHARGES	2,015,960.31	CONTRACTUAL ALLOW	1,918,973.64
NON-COVERD CHARGES	242,070.00	TOTAL MEDICAID LIAB	96,986.67
		LESS: COB	3,580.75
		LESS: COPAYMENT	2,499.00
		REIMBURSEMENT	90,906.92
		TOTAL NUMBER OF CLAIMS	1,670

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,195.75	106.75	OTHER LAB	9,496.00	1,806.00
MED/SURG SUPPLY	8,328.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,385.00	702.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	80,669.00	15,708.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	422,207.00	30,308.00
EKG/ECG	24,748.00	0.00	MRI SERVICES	15,261.00	0.00
IV THERAPY	85,562.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,856.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,592.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,397.00	796.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	424.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,106,993.00	2,217.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,803.50	24,641.25
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	321.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	154,143.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	504.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93.00	1,257.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,877.00	9,560.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,073.06	0.00			
			TOTAL ANCILLARY	2,015,960.31	242,070.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,015,960.31	242,070.00

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: 09/24/2013  
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Page: 13

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

PROVIDER NUMBER  
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,748.00	ADJUSTMENTS	0.00
COVERED CHARGES	42,284.00	CONTRACTUAL ALLOW	16,824.97
NON-COVERD CHARGES	3,464.00	TOTAL MEDICAID LIAB	25,459.03
		LESS: COB	25,429.03
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	29

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	969.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	342.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	106.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,453.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,244.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,050.00	154.00
EKG/ECG	538.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,706.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	424.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,314.00	58.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,912.00	478.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,284.00	3,464.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,284.00	3,464.00

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 COBB HOSPITAL  
3950 AUSTELL RD  
AUSTELL,GA 30106-1121

PROVIDER NUMBER  
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,715,127.83	ADJUSTMENTS	188,728.42
COVERED CHARGES	3,441,979.48	CONTRACTUAL ALLOW	2,978,135.11
NON-COVERD CHARGES	273,148.35	TOTAL MEDICAID LIAB	463,844.37
		LESS: COB	0.00
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	463,280.37

TOTAL NUMBER OF CLAIMS 93

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,774.50	0.00	OTHER LAB	2,810.00	0.00
MED/SURG SUPPLY	100,871.64	7.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,159.00	29,765.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,418.00	2,244.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	498.00	FEE SCHEDULE LAB	80,652.40	13,260.60
EKG/ECG	5,918.00	323.00	MRI SERVICES	13,611.00	0.00
IV THERAPY	65,809.00	66.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	331,507.00	56,081.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,220.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,532.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,394.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,896.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,765,806.00	165,616.75
RADIOLOGY THERAPEUTIC	97,188.00	1,539.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,512.00	72.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	540,642.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,894.00	1,006.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,896.00	1,666.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,440.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,642.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,386.18	1,004.00			
			TOTAL ANCILLARY	3,441,979.48	273,148.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,441,979.48	273,148.35



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

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

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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:51:24  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER 000000437A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	679,602.85	ADJUSTMENTS	10,462.15
COVERED CHARGES	671,359.85	CONTRACTUAL ALLOW	288,979.23
NON-COVERD CHARGES	8,243.00	TOTAL MEDICAID LIAB	382,380.62
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	382,380.62

TOTAL NUMBER OF ADMISSIONS 88

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	145		0	55,535.00		2,719.00
ROUTINE NURSERY	63		0	13,500.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	208		0	69,035.00		2,719.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	50		0	47,700.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	50		0	47,700.00		0.00
TOTAL ACCOMODATIONS	258		0	116,735.00		2,719.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,184.51	0.00	OTHER LAB	5,104.00	0.00
MED/SURG SUPPLY	52,515.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	108,893.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,829.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,161.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,997.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,864.00	0.00	MRI SERVICES	4,046.00	0.00
IV THERAPY	530.00	0.00	PROFESSIONAL FEES	0.00	105.00
OPERATING ROOM	3,159.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	74,269.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,177.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,286.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,718.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,583.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	300.00	0.00	INJECTABLE DRUGS	103,223.86	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	253.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	497.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	300.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,276.00
OTHER IMAGING SERVICE	3,633.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,201.00	3,843.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,290.00	0.00			
CARDIOLOGY	6,540.00	0.00			
AMBULATORY SURGERY	5,560.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	830.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,981.00	0.00			
			TOTAL ANCILLARY	554,624.85	5,524.00
			TOTAL ACCOMODATIONS	116,735.00	2,719.00
			TOTAL CHARGES	671,359.85	8,243.00

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: 09/24/2013  
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TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012227011367	04/25/12 - 04/27/12	08/20/12	0.00	1,276.00	0.00	0.00	0.00
TOTAL				0.00	1,276.00	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: 09/24/2013  
 Run Time: 14:51:28  
 Page: 4

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,160.91	ADJUSTMENTS	0.00
COVERED CHARGES	23,442.91	CONTRACTUAL ALLOW	10,642.91
NON-COVERD CHARGES	718.00	TOTAL MEDICAID LIAB	12,800.00
		LESS: COB	12,800.00
		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	13		0	4,979.00		208.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13		0	4,979.00		208.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	13		0	4,979.00		208.00

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

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

Run Date: 09/24/2013  
Run Time: 14:51:28  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98.06	0.00	OTHER LAB	585.00	0.00
MED/SURG SUPPLY	806.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,225.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	995.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,407.00	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	21.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,396.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,930.37	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	510.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,463.91	510.00
			TOTAL ACCOMODATIONS	4,979.00	208.00
			TOTAL CHARGES	23,442.91	718.00

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: 09/24/2013  
Run Time: 14:51:28  
Page: 6

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	955,912.02	ADJUSTMENTS	82,299.56
COVERED CHARGES	900,875.09	CONTRACTUAL ALLOW	654,360.58
NON-COVERD CHARGES	55,036.93	TOTAL MEDICAID LIAB	246,514.51
		LESS: COB	211.44
		LESS: COPAYMENT	681.00
		REIMBURSEMENT	245,622.07
		ALL OTHER	212,265.83
		FEE SCHEDULE-LAB	27,153.08
		INJECTABLE DRUGS	6,203.16

TOTAL NUMBER OF CLAIMS 895

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,122.58	0.00	OTHER LAB	3,793.00	0.00
MED/SURG SUPPLY	24,514.46	364.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,226.00	417.00	OTHER THERAPEUTIC SVC	0.00	1,920.00
CT SCAN	119,650.00	5,637.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,797.00	2,452.00	FEE SCHEDULE LAB	215,996.00	24,264.00
EKG/ECG	12,160.00	0.00	MRI SERVICES	28,188.00	1,166.00
IV THERAPY	50,747.00	288.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,558.00	2,147.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,351.00	4,945.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,262.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	261,011.00	2,122.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,250.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,859.05	5,844.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	253.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	882.00	1,448.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,548.00	842.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	568.00	927.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,720.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,245.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,427.00	0.00			
			TOTAL ANCILLARY	900,875.09	55,036.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	900,875.09	55,036.93



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: 09/24/2013  
Run Time: 14:51:59  
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,499.78	ADJUSTMENTS	0.00
COVERED CHARGES	25,675.34	CONTRACTUAL ALLOW	6,117.22
NON-COVERD CHARGES	4,824.44	TOTAL MEDICAID LIAB	19,558.12
		LESS: COB	19,558.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

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

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,362.78	0.00	OTHER LAB	430.00	0.00
MED/SURG SUPPLY	332.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,651.00	107.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,059.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,576.00	954.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,436.00	1,995.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	940.56	288.44
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	248.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,257.00	421.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	1,390.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,675.34	4,824.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,675.34	4,824.44

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

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

Run Date: 09/24/2013  
Run Time: 14:52:00  
Page: 10

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	103,184.20	ADJUSTMENTS	1,873.90
COVERED CHARGES	99,523.20	CONTRACTUAL ALLOW	91,579.73
NON-COVERD CHARGES	3,661.00	TOTAL MEDICAID LIAB	7,943.47
		LESS: COB	0.00
		LESS: COPAYMENT	270.00
		REIMBURSEMENT	7,673.47

TOTAL NUMBER OF CLAIMS 142

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	377.02	0.00	OTHER LAB	575.00	0.00
MED/SURG SUPPLY	475.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,014.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,755.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,531.00	3,108.00
EKG/ECG	1,368.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	260.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,979.00	553.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,668.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,152.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,368.00	0.00			
			TOTAL ANCILLARY	99,523.20	3,661.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	99,523.20	3,661.00

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

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

Run Date: 09/24/2013  
Run Time: 14:52:04  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,082.43	ADJUSTMENTS	0.00
COVERED CHARGES	6,608.43	CONTRACTUAL ALLOW	2,774.63
NON-COVERD CHARGES	1,474.00	TOTAL MEDICAID LIAB	3,833.80
		LESS: COB	3,830.80
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	840.19	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,059.00	1,059.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,726.00	28.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,870.00	387.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	113.24	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,608.43	1,474.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,608.43	1,474.00

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: 09/24/2013  
Run Time: 14:52:05  
Page: 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,503.58	ADJUSTMENTS	4,967.71
COVERED CHARGES	18,014.92	CONTRACTUAL ALLOW	13,047.21
NON-COVERD CHARGES	3,488.66	TOTAL MEDICAID LIAB	4,967.71
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,967.71

TOTAL NUMBER OF CLAIMS 1

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

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	365.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,620.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	341.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,564.00	2,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,178.00	542.00
EKG/ECG	152.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,136.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	382.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,679.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,666.11	61.66
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	676.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,027.00	214.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	541.00	0.00			
			TOTAL ANCILLARY	18,014.92	3,488.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,014.92	3,488.66



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

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

Run Date: 09/24/2013  
Run Time: 14:52:05  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:52:13  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,136,717.00	ADJUSTMENTS	44,107.02
COVERED CHARGES	1,119,190.00	CONTRACTUAL ALLOW	569,871.89
NON-COVERD CHARGES	17,527.00	TOTAL MEDICAID LIAB	549,318.11
		LESS: COB	2,440.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	546,877.72

TOTAL NUMBER OF ADMISSIONS 99

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	231		2	92,169.00		10,118.00
ROUTINE NURSERY	42		0	11,862.00		530.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	273		2	104,031.00		10,648.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	20		0	20,980.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	20,980.00		0.00
TOTAL ACCOMODATIONS	293		2	125,011.00		10,648.00

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,366.65	0.00	OTHER LAB	6,684.00	0.00
MED/SURG SUPPLY	93,886.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	180,348.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,820.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,892.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,748.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,480.00	0.00	MRI SERVICES	4,706.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,420.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,719.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	113,465.00	642.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,222.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	73,662.00	0.00	SPECIAL SERVICES	0.00	165.00
RECOVERY ROOM	3,757.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,483.00	33.00	INJECTABLE DRUGS	159,443.51	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,013.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,790.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	500.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	823.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,634.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,809.00	5,184.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,197.00	355.00			
AUDIOLOGY	940.00	0.00			
CARDIOLOGY	20,055.00	0.00			
AMBULATORY SURGERY	1,529.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,930.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,356.00	0.00			
			TOTAL ANCILLARY	994,179.00	6,879.00
			TOTAL ACCOMODATIONS	125,011.00	10,648.00
			TOTAL CHARGES	1,119,190.00	17,527.00

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

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

Run Date: 09/24/2013  
Run Time: 14:52:22  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 14:52:22  
Page: 4

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,072,112.05	ADJUSTMENTS	46,122.19
COVERED CHARGES	1,815,679.78	CONTRACTUAL ALLOW	1,336,097.67
NON-COVERD CHARGES	256,432.27	TOTAL MEDICAID LIAB	479,582.11
		LESS: COB	1,591.32
		LESS: COPAYMENT	1,103.28
		REIMBURSEMENT	476,887.51
		ALL OTHER	433,337.86
		FEE SCHEDULE-LAB	40,945.45
		INJECTABLE DRUGS	2,604.20

TOTAL NUMBER OF CLAIMS 1,359

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

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

Run Date: 09/24/2013  
 Run Time: 14:52:22  
 Page: 5

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,657.22	31,582.73	OTHER LAB	8,319.00	452.00
MED/SURG SUPPLY	61,190.40	14,444.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	84.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,600.00	2,095.00	OTHER THERAPEUTIC SVC	0.00	3,922.00
CT SCAN	240,741.00	8,536.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	902.00	12,467.00	FEE SCHEDULE LAB	369,760.00	39,886.10
EKG/ECG	22,475.00	960.00	MRI SERVICES	39,430.00	3,008.00
IV THERAPY	74,241.00	6,240.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,292.00	9,658.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,145.00	14,947.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	222.00	AMBULANCE	0.00	0.00
GI SERVICES	39,670.16	10,211.84	CAST ROOM	0.00	0.00
EMERGENCY ROOM	446,189.00	27,087.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,025.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	74,148.00	47,501.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,290.00	4,156.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	830.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	700.00	2,628.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,004.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	59,841.00	1,098.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,800.00	3,988.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,555.00	8,688.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,871.00	1,337.00			
AMBULATORY SURGERY	1,529.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,663.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,642.00	403.00			
			TOTAL ANCILLARY	1,815,679.78	256,432.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,815,679.78	256,432.27

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

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

Run Date: 09/24/2013  
Run Time: 14:53:10  
Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,712.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,494.00	CONTRACTUAL ALLOW	5,867.50
NON-COVERD CHARGES	4,218.00	TOTAL MEDICAID LIAB	13,626.50
		LESS: COB	13,623.93
		LESS: COPAYMENT	2.57
		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

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81.00	236.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	457.00	194.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,211.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,396.00	1,001.00
EKG/ECG	160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,667.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,899.00	293.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,261.00	222.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	624.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,130.00	605.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,494.00	4,218.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,494.00	4,218.00



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: 09/24/2013  
Run Time: 14:53:11  
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TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	145,730.18	ADJUSTMENTS	326.64
COVERED CHARGES	136,504.18	CONTRACTUAL ALLOW	125,707.76
NON-COVERD CHARGES	9,226.00	TOTAL MEDICAID LIAB	10,796.42
		LESS: COB	0.00
		LESS: COPAYMENT	324.02
		REIMBURSEMENT	10,472.40
		TOTAL NUMBER OF CLAIMS	193

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165.00	664.00	OTHER LAB	698.00	0.00
MED/SURG SUPPLY	1,600.00	80.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,460.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,928.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,466.00	2,366.00
EKG/ECG	640.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	88.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,288.00	2,539.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,746.18	3,489.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,513.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	136,504.18	9,226.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	136,504.18	9,226.00

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,220.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,177.00	CONTRACTUAL ALLOW	1,991.14
NON-COVERD CHARGES	43.00	TOTAL MEDICAID LIAB	2,185.86
		LESS: COB	2,176.86
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	242.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	649.00	15.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,819.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	467.00	28.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,177.00	43.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,177.00	43.00

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	12/31/12
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

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000448A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,043,199.78	ADJUSTMENTS	398,006.83
COVERED CHARGES	10,758,921.78	CONTRACTUAL ALLOW	6,320,207.54
NON-COVERD CHARGES	284,278.00	TOTAL MEDICAID LIAB	4,438,714.24
		LESS: COB	77,424.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,361,289.48

TOTAL NUMBER OF ADMISSIONS 637

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,035		0	1,207,627.00		55,750.00
ROUTINE NURSERY	68		0	34,797.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		3,750.00
TOTAL ROUTINE	2,103		0	1,242,424.00		59,500.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	250		0	282,797.00		0.00
NICU	2		0	1,250.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	252		0	284,047.00		0.00
TOTAL ACCOMODATIONS	2,355		0	1,526,471.00		59,500.00

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,688,807.53	6,158.00	OTHER LAB	54,277.00	0.00
MED/SURG SUPPLY	466,261.75	6,530.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,355,243.00	2,589.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	238,799.25	949.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	529,169.00	58,752.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,142.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	329,512.00	848.00	MRI SERVICES	83,973.00	0.00
IV THERAPY	210,847.00	75.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	923,940.00	252.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,414.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	681,779.00	6,006.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	133,387.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	195,221.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	301,986.00	246.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,854.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	18,773.00
LABORATORY PATHOLOGIC	26,197.00	0.00	INJECTABLE DRUGS	28,118.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	820.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	38,217.00	2,989.00	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	0.00	0.00	IMPL DEV CHARGE PATIENTS	139,196.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,246.00
OTHER IMAGING SERVICE	53,417.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	85,273.00	82,784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	191,679.00	24,505.00			
AUDIOLOGY	2,730.00	0.00			
CARDIOLOGY	286,299.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,470.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,897.00	76.00			
			TOTAL ANCILLARY	9,232,450.78	224,778.00
			TOTAL ACCOMODATIONS	1,526,471.00	59,500.00
			TOTAL CHARGES	10,758,921.78	284,278.00



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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012111081343	04/13/12 - 04/16/12	04/30/12	0.00	2,491.00	0.00	0.00	0.00
615	2012160082543	05/29/12 - 05/31/12	06/18/12	0.00	2,491.00	0.00	0.00	0.00
615	2012278053439	09/25/12 - 09/29/12	10/08/12	0.00	2,491.00	0.00	0.00	0.00
-1	9113056009329	02/19/12 - 03/04/12	04/01/13	0.00	791.00	0.00	2,417.16	0.00
615	9113115004360	12/11/12 - 12/13/12	05/27/13	0.00	4,982.00	0.00	3,006.78	0.00
TOTAL				0.00	13,246.00	0.00	5,423.94	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000448A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	137,780.00	ADJUSTMENTS	0.00
COVERED CHARGES	135,891.00	CONTRACTUAL ALLOW	53,740.58
NON-COVERD CHARGES	1,889.00	TOTAL MEDICAID LIAB	82,150.42
		LESS: COB	82,150.42
		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	33		0	19,437.00		1,211.00
ROUTINE NURSERY	3		0	1,524.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	36		0	20,961.00		1,211.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	4,362.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	4,362.00		0.00
TOTAL ACCOMODATIONS	40		0	25,323.00		1,211.00

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

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

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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000448A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,435.00	0.00	OTHER LAB	513.00	0.00
MED/SURG SUPPLY	5,986.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,414.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,259.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,118.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	565.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,524.00	0.00	MRI SERVICES	4,896.00	0.00
IV THERAPY	988.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,944.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	238.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,313.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,000.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,857.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,100.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	464.00	0.00	INJECTABLE DRUGS	86.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,726.00	678.00			
AUDIOLOGY	70.00	0.00			
CARDIOLOGY	4,509.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	563.00	0.00			
			TOTAL ANCILLARY	110,568.00	678.00
			TOTAL ACCOMODATIONS	25,323.00	1,211.00
			TOTAL CHARGES	135,891.00	1,889.00

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: 09/24/2013  
Run Time: 14:53:59  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,967,760.10	ADJUSTMENTS	574,247.62
COVERED CHARGES	8,344,097.35	CONTRACTUAL ALLOW	6,487,772.57
NON-COVERD CHARGES	623,662.75	TOTAL MEDICAID LIAB	1,856,324.78
		LESS: COB	14,167.69
		LESS: COPAYMENT	4,906.10
		REIMBURSEMENT	1,837,250.99
		ALL OTHER	1,643,703.04
		FEE SCHEDULE-LAB	178,814.81
		INJECTABLE DRUGS	14,733.14
		TOTAL NUMBER OF CLAIMS	4,921

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	464,124.60	1,497.00	OTHER LAB	43,309.00	1,539.00
MED/SURG SUPPLY	252,183.00	1,288.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,708.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	398,528.00	21,614.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	923,613.00	53,968.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,399.00	3,086.00	FEE SCHEDULE LAB	1,778,886.60	167,827.20
EKG/ECG	129,385.00	2,952.00	MRI SERVICES	203,737.00	19,985.00
IV THERAPY	422,629.00	115,518.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	923,829.21	95,174.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,438.00	238.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107,025.00	18,970.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	230,515.00	2,612.00	AMBULANCE	0.00	0.00
GI SERVICES	92,167.00	15,021.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,058,825.00	1,168.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	58,591.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,342.00	29,571.00
RADIOLOGY THERAPEUTIC	1,335.00	445.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,542.00	5,236.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,333.00	25,859.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,491.00
OTHER IMAGING SERVICE	173,741.00	8,076.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,762.00	834.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	352,457.00	227.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	207,768.00	21,800.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	111,044.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	215,588.94	2,957.76			
			TOTAL ANCILLARY	8,344,097.35	623,662.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,344,097.35	623,662.75

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: 09/24/2013  
Run Time: 14:53:59  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9712265957015	02/27/12 - 02/27/12	09/24/12	0.00	2,491.00	0.00	0.00	0.00
TOTAL				0.00	2,491.00	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: 09/24/2013  
Run Time: 14:56:07  
Page: 9

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	157,484.44	ADJUSTMENTS	0.00
COVERED CHARGES	142,832.24	CONTRACTUAL ALLOW	66,766.05
NON-COVERD CHARGES	14,652.20	TOTAL MEDICAID LIAB	76,066.19
		LESS: COB	76,027.19
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 86

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,350.00	1,662.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,482.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	265.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,288.00	420.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,078.00	5,140.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,537.00	1,586.00
EKG/ECG	1,476.00	0.00	MRI SERVICES	4,866.00	0.00
IV THERAPY	5,835.00	2,622.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,939.80	313.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	764.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,403.00	854.00	FREE STANDING CLINIC	133.00	0.00
ANESTHESIA	5,330.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,425.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	550.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,135.00	442.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,198.00	514.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,618.00	834.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,374.44	0.00			
			TOTAL ANCILLARY	142,832.24	14,652.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	142,832.24	14,652.20



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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	518,296.08	ADJUSTMENTS	2,147.60
COVERED CHARGES	508,225.08	CONTRACTUAL ALLOW	465,822.56
NON-COVERD CHARGES	10,071.00	TOTAL MEDICAID LIAB	42,402.52
		LESS: COB	27.39
		LESS: COPAYMENT	1,323.00
		REIMBURSEMENT	41,052.13
		TOTAL NUMBER OF CLAIMS	758

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,566.00	185.00	OTHER LAB	1,604.00	0.00
MED/SURG SUPPLY	4,846.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,024.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,381.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	112,968.00	4,146.00
EKG/ECG	3,772.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,406.00	3,465.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,632.00	1,247.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	242,117.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,640.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,270.00	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	1,999.08	0.00			
			TOTAL ANCILLARY	508,225.08	10,071.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	508,225.08	10,071.00

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

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

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

PROVIDER NUMBER  
000000448A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,428.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,408.00	CONTRACTUAL ALLOW	5,815.19
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	2,592.81
		LESS: COB	2,577.81
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15

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

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

Run Date: 09/24/2013  
 Run Time: 14:56:26  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	171.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	176.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	313.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,919.00	20.00
EKG/ECG	164.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	282.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,015.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	368.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,408.00	20.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,408.00	20.00

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

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

Run Date: 09/24/2013  
Run Time: 14:56:27  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	737,817.45	ADJUSTMENTS	41,152.60
COVERED CHARGES	722,610.55	CONTRACTUAL ALLOW	619,556.55
NON-COVERD CHARGES	15,206.90	TOTAL MEDICAID LIAB	103,054.00
		LESS: COB	0.00
		LESS: COPAYMENT	99.00
		REIMBURSEMENT	102,955.00
		TOTAL NUMBER OF CLAIMS	20

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,005.80	24.00	OTHER LAB	2,682.00	0.00
MED/SURG SUPPLY	8,049.00	306.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,653.00	2,588.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,262.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,303.00	0.00	FEE SCHEDULE LAB	29,304.10	7,250.90
EKG/ECG	4,089.00	1,148.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,624.00	1,770.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	372,344.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,585.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,400.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,544.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,136.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,060.00	846.00
RADIOLOGY THERAPEUTIC	566.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,576.00	596.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	78,438.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	589.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,300.00	678.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	61,203.00	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	8,297.65	0.00			
			TOTAL ANCILLARY	722,610.55	15,206.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	722,610.55	15,206.90

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: 09/24/2013  
Run Time: 14:56:29  
Page: 17

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

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000459A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,915,428.87	ADJUSTMENTS	2,016,992.37
COVERED CHARGES	36,733,354.13	CONTRACTUAL ALLOW	26,733,736.25
NON-COVERD CHARGES	1,182,074.74	TOTAL MEDICAID LIAB	9,999,617.88
		LESS: COB	108,991.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,890,626.11

TOTAL NUMBER OF ADMISSIONS 864

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,035		0	2,461,385.00		605,036.04
ROUTINE NURSERY	276		0	535,941.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,311		0	2,997,326.00		605,036.04
SPECIAL CARE SERVICES						
CCU	198		0	421,904.00		0.00
ICU	1,427		2	3,308,018.00		3,746.00
NICU	136		0	471,944.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		15	0.00		15,105.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,761		17	4,201,866.00		18,851.00
TOTAL ACCOMODATIONS	5,072		17	7,199,192.00		623,887.04



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

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

Run Date: 09/24/2013  
 Run Time: 14:56:38  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,739,392.82	2,144.55	OTHER LAB	190,700.50	0.00
MED/SURG SUPPLY	1,649,538.00	8,602.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,384,176.25	275.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	867,226.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	829,766.75	267,490.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	466,067.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	267,745.00	0.00	MRI SERVICES	316,304.25	0.00
IV THERAPY	30,673.25	403.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,156,122.75	11,575.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	270,156.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,667,741.35	6,408.15	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	639,301.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	151,430.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	713,056.50	1,106.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	403,268.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	181,242.50
LABORATORY PATHOLOGIC	91,328.75	0.00	INJECTABLE DRUGS	5,618,531.11	16,738.75
RADIOLOGY THERAPEUTIC	588.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	401,090.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	143,385.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	167,521.25	29,301.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	761.75	126.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	619,742.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	241,981.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	334,904.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	123,517.25	32,773.25			
AUDIOLOGY	10,423.00	0.00			
CARDIOLOGY	1,992,377.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,733.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,609.50	0.00			
			TOTAL ANCILLARY	29,534,162.13	558,187.70
			TOTAL ACCOMODATIONS	7,199,192.00	623,887.04
			TOTAL CHARGES	36,733,354.13	1,182,074.74

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

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

Run Date: 09/24/2013  
 Run Time: 14:57:30  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000459A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	267,257.00	ADJUSTMENTS	0.00
COVERED CHARGES	266,777.00	CONTRACTUAL ALLOW	61,402.32
NON-COVERD CHARGES	480.00	TOTAL MEDICAID LIAB	205,374.68
		LESS: COB	205,374.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	20		0	16,220.00		480.00
ROUTINE NURSERY	29		0	98,089.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	49		0	114,309.00		480.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	10		0	34,820.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	34,820.00		0.00
TOTAL ACCOMODATIONS	59		0	149,129.00		480.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,308.50	0.00	OTHER LAB	1,300.50	0.00
MED/SURG SUPPLY	1,587.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,591.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,747.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	46,659.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	871.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	423.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,931.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,109.75	0.00	INJECTABLE DRUGS	13,221.75	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	258.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	886.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,189.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,559.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	117,648.00	0.00
			TOTAL ACCOMODATIONS	149,129.00	480.00
			TOTAL CHARGES	266,777.00	480.00

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: 09/24/2013  
Run Time: 14:57:31  
Page: 5

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,876,686.38	ADJUSTMENTS	168,380.85
COVERED CHARGES	9,617,124.96	CONTRACTUAL ALLOW	7,799,553.75
NON-COVERD CHARGES	1,259,561.42	TOTAL MEDICAID LIAB	1,817,571.21
		LESS: COB	7,113.37
		LESS: COPAYMENT	2,137.11
		REIMBURSEMENT	1,808,320.73
		ALL OTHER	1,611,900.42
		FEE SCHEDULE-LAB	150,476.51
		INJECTABLE DRUGS	45,943.80

TOTAL NUMBER OF CLAIMS 3,354

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	269,512.97	369.00	OTHER LAB	64,495.50	6,723.25
MED/SURG SUPPLY	182,707.64	278.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,791.50	0.00
RADIOLOGY-DIAGNOSTIC	710,718.75	27,378.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,508,559.75	218,218.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	443.25	0.00	FEE SCHEDULE LAB	1,978,966.49	258,332.25
EKG/ECG	186,224.75	5,036.00	MRI SERVICES	103,326.25	20,845.00
IV THERAPY	165,786.97	7,739.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	669,972.54	158,644.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,065.00	8,620.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,410.75	1,762.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	258,175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	218,220.11	24,592.13	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,720,113.00	92,455.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	202,634.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	811.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	381,347.38	130,683.87
RADIOLOGY THERAPEUTIC	7,109.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,421.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,690.50	1,370.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,361.00	67,651.00
LITHOTRIPSY	0.00	12,071.50	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	265,345.61	36,295.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,098.50	1,040.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	50,568.75	41,624.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	530,177.25	133,810.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,140.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,739.25	3,206.25			
			TOTAL ANCILLARY	9,617,124.96	1,259,561.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,617,124.96	1,259,561.42

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

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

Run Date: 09/24/2013  
Run Time: 14:59:23  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	302,973.00	ADJUSTMENTS	0.00
COVERED CHARGES	234,431.50	CONTRACTUAL ALLOW	155,441.22
NON-COVERD CHARGES	68,541.50	TOTAL MEDICAID LIAB	78,990.28
		LESS: COB	78,908.86
		LESS: COPAYMENT	81.42
		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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,854.25	0.00	OTHER LAB	2,555.00	0.00
MED/SURG SUPPLY	3,906.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,966.50	0.00	OTHER THERAPEUTIC SVC	0.00	2,129.75
CT SCAN	2,198.00	31,671.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	49,917.00	4,928.00
EKG/ECG	5,350.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,456.25	371.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,659.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	1,502.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	932.50	198.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,788.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	9,358.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,706.75	757.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,095.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,291.75	2,981.50
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	43.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,717.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,578.00	2,428.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	41,620.25	8,981.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,875.00	472.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,924.50	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	755.00	0.00			
			TOTAL ANCILLARY	234,431.50	68,541.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	234,431.50	68,541.50

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: 09/24/2013  
Run Time: 14:59:27  
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COLISEUM MEDICAL CENTER  
350 HOSPITAL DR  
MACON,GA 31217-3838

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	592,472.50	ADJUSTMENTS	482.46
COVERED CHARGES	565,057.75	CONTRACTUAL ALLOW	539,437.23
NON-COVERD CHARGES	27,414.75	TOTAL MEDICAID LIAB	25,620.52
		LESS: COB	0.00
		LESS: COPAYMENT	840.01
		REIMBURSEMENT	24,780.51
		TOTAL NUMBER OF CLAIMS	458



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

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

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,424.50	96.50	OTHER LAB	1,085.00	986.25
MED/SURG SUPPLY	1,418.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,505.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,428.50	6,457.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	124,395.00	8,667.75
EKG/ECG	5,350.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,444.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,090.00	206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,357.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	295,997.25	2,627.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,802.50	2,189.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,294.50	5,786.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,465.75	398.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	565,057.75	27,414.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	565,057.75	27,414.75

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

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,067.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,160.50	CONTRACTUAL ALLOW	5,327.65
NON-COVERD CHARGES	3,906.50	TOTAL MEDICAID LIAB	3,832.85
		LESS: COB	3,814.85
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	419.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,228.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,734.50	678.00
EKG/ECG	314.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,686.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,160.50	3,906.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,160.50	3,906.50

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

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

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,428,834.48	ADJUSTMENTS	38,090.21
COVERED CHARGES	2,158,100.05	CONTRACTUAL ALLOW	1,874,896.09
NON-COVERD CHARGES	270,734.43	TOTAL MEDICAID LIAB	283,203.96
		LESS: COB	0.00
		LESS: COPAYMENT	287.01
		REIMBURSEMENT	282,916.95

TOTAL NUMBER OF CLAIMS 52

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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,613.60	0.00	OTHER LAB	986.25	0.00
MED/SURG SUPPLY	115,014.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,240.00	5,830.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	70,499.75	25,214.64
EKG/ECG	17,311.25	3,777.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,174.00	192.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	498,862.23	7,069.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	252.00	144.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	128,211.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,202.75	1,048.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,798.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	459,184.55	55,651.75
RADIOLOGY THERAPEUTIC	8,676.00	438.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	84.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200,641.50	133,382.50
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	7,246.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	505,560.88	30,655.12			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,870.75	0.00			
			TOTAL ANCILLARY	2,158,100.05	270,734.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,158,100.05	270,734.43

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

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 14:59:53  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000492A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,960,928.29	ADJUSTMENTS	116,315.07
COVERED CHARGES	14,756,473.29	CONTRACTUAL ALLOW	10,544,241.15
NON-COVERD CHARGES	204,455.00	TOTAL MEDICAID LIAB	4,212,232.14
		LESS: COB	20,381.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,191,851.00

TOTAL NUMBER OF ADMISSIONS 597

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,435		0	831,980.00		42,930.00
ROUTINE NURSERY	300		0	217,200.00		112,940.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,735		0	1,049,180.00		155,870.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	750		0	984,887.50		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	750		0	984,887.50		0.00
TOTAL ACCOMODATIONS	2,485		0	2,034,067.50		155,870.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,775,494.82	0.00	OTHER LAB	91,140.00	0.00
MED/SURG SUPPLY	888,465.25	1,230.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,799,286.00	498.00	EDUCATION & TRAINING	91.00	0.00
RADIOLOGY-DIAGNOSTIC	429,691.62	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	906,411.00	19,963.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,085.60	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	109,032.00	0.00	MRI SERVICES	126,345.00	5,372.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,176,058.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	256,415.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	719,635.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	237,477.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	572,562.00	209.00	SPECIAL SERVICES	0.00	3,927.00
RECOVERY ROOM	346,432.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	26,237.00	0.00	INJECTABLE DRUGS	614.00	0.00
RADIOLOGY THERAPEUTIC	300.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	29,569.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	47,376.00	1,692.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	228.00	665.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	348,740.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	10,744.00
OTHER IMAGING SERVICE	71,697.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	207,015.00	4,100.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	96,334.00	0.00			
AUDIOLOGY	16,343.00	185.00			
CARDIOLOGY	349,537.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,154.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,640.00	0.00			
			TOTAL ANCILLARY	12,722,405.79	48,585.00
			TOTAL ACCOMODATIONS	2,034,067.50	155,870.00
			TOTAL CHARGES	14,756,473.29	204,455.00



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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212087005467	01/06/12 - 01/09/12	04/02/12	0.00	2,686.00	0.00	0.00	0.00
615	2012165065387	09/29/11 - 10/03/11	06/18/12	0.00	2,686.00	0.00	0.00	0.00
615	2012178063302	06/10/12 - 06/12/12	07/02/12	0.00	2,686.00	0.00	0.00	0.00
615	2212261005495	03/01/12 - 03/14/12	09/24/12	0.00	2,686.00	0.00	0.00	0.00
TOTAL				0.00	10,744.00	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: 09/24/2013  
 Run Time: 15:00:15  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,906.00	ADJUSTMENTS	0.00
COVERED CHARGES	37,010.00	CONTRACTUAL ALLOW	22,218.26
NON-COVERD CHARGES	2,896.00	TOTAL MEDICAID LIAB	14,791.74
		LESS: COB	14,791.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	4,060.00		210.00
ROUTINE NURSERY	0		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	4,060.00		210.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,060.00		210.00

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,574.00	0.00	OTHER LAB	1,311.00	0.00
MED/SURG SUPPLY	2,936.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,515.00	0.00	EDUCATION & TRAINING	91.00	0.00
RADIOLOGY-DIAGNOSTIC	289.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,084.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	248.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	462.00	0.00	MRI SERVICES	2,558.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,264.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	954.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,206.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	593.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,017.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,094.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	745.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,686.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,009.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,950.00	2,686.00
			TOTAL ACCOMODATIONS	4,060.00	210.00
			TOTAL CHARGES	37,010.00	2,896.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1112326003595	12/21/11 - 12/26/11	12/03/12	0.00	2,686.00	0.00	8,763.54	0.00
TOTAL				0.00	2,686.00	0.00	8,763.54	0.00

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

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

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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,815,692.79	ADJUSTMENTS	516,072.30
COVERED CHARGES	13,614,794.69	CONTRACTUAL ALLOW	11,033,790.45
NON-COVERD CHARGES	1,200,898.10	TOTAL MEDICAID LIAB	2,581,004.24
		LESS: COB	8,414.63
		LESS: COPAYMENT	4,320.00
		REIMBURSEMENT	2,568,269.61
		ALL OTHER	2,388,502.61
		FEE SCHEDULE-LAB	168,597.02
		INJECTABLE DRUGS	11,169.98
		TOTAL NUMBER OF CLAIMS	4,567

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,176,106.10	4,597.00	OTHER LAB	237,715.00	524.00
MED/SURG SUPPLY	538,423.25	113.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,352.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	707,016.00	21,433.00	OTHER THERAPEUTIC SVC	0.00	429.00
CT SCAN	2,039,963.00	156,019.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,663.25	21,690.00	FEE SCHEDULE LAB	2,612,656.09	361,230.10
EKG/ECG	179,365.00	1,155.00	MRI SERVICES	186,252.00	37,717.00
IV THERAPY	26,087.00	418.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,385,397.25	101,272.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	109,568.00	2,575.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	90,340.00	85,421.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	273,604.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,696.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,145,723.00	161,837.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	304,332.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	234,994.00	68,521.00
RADIOLOGY THERAPEUTIC	43,134.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,377.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,692.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	42,360.00	5,007.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	72,391.75	9,868.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	367,035.00	103,632.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	80,408.00	2,649.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	270,994.00	2,450.00			
AUDIOLOGY	100.00	0.00			
CARDIOLOGY	290,366.00	42,602.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,148.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	163,957.00	2,294.00			
			TOTAL ANCILLARY	13,614,794.69	1,198,874.10
			TOTAL ACCOMODATIONS	0.00	2,024.00
			TOTAL CHARGES	13,614,794.69	1,200,898.10

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

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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	191,282.75	ADJUSTMENTS	0.00
COVERED CHARGES	146,453.75	CONTRACTUAL ALLOW	91,203.28
NON-COVERD CHARGES	44,829.00	TOTAL MEDICAID LIAB	55,250.47
		LESS: COB	55,217.47
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 73

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
 000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,285.00	0.00	OTHER LAB	3,702.00	0.00
MED/SURG SUPPLY	3,876.75	87.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,183.00	557.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,428.00	20,336.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,624.00	4,890.00
EKG/ECG	3,003.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,649.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,469.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.00	390.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,044.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,553.00	1,721.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,566.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	534.00	2,708.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	76.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,230.00	12,057.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,844.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,143.00	2,007.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	720.00	0.00			
			TOTAL ANCILLARY	146,453.75	44,829.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	146,453.75	44,829.00



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

PROVIDER NUMBER  
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	566,800.00	ADJUSTMENTS	1,630.18
COVERED CHARGES	536,804.00	CONTRACTUAL ALLOW	508,274.63
NON-COVERD CHARGES	29,996.00	TOTAL MEDICAID LIAB	28,529.37
		LESS: COB	0.00
		LESS: COPAYMENT	789.03
		REIMBURSEMENT	27,740.34
		TOTAL NUMBER OF CLAIMS	510

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,209.00	0.00	OTHER LAB	2,826.00	0.00
MED/SURG SUPPLY	7,165.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,507.00	557.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,197.00	12,000.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	131,891.00	6,882.00
EKG/ECG	6,006.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,753.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	251,759.00	4,653.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,247.00	774.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	152.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,244.00	4,978.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	536,804.00	29,996.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	536,804.00	29,996.00

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

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,212.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,465.00	CONTRACTUAL ALLOW	13,316.25
NON-COVERD CHARGES	1,747.00	TOTAL MEDICAID LIAB	2,148.75
		LESS: COB	2,130.74
		LESS: COPAYMENT	18.01
		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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	532.00	0.00	OTHER LAB	644.00	0.00
MED/SURG SUPPLY	218.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,750.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,807.00	1,747.00
EKG/ECG	462.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,072.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	260.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	720.00	0.00			
			TOTAL ANCILLARY	15,465.00	1,747.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,465.00	1,747.00

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

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

Run Date: 09/24/2013  
Run Time: 15:02:28  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,220,989.82	ADJUSTMENTS	50,119.90
COVERED CHARGES	1,206,291.82	CONTRACTUAL ALLOW	1,041,344.35
NON-COVERD CHARGES	14,698.00	TOTAL MEDICAID LIAB	164,947.47
		LESS: COB	0.00
		LESS: COPAYMENT	198.00
		REIMBURSEMENT	164,749.47

TOTAL NUMBER OF CLAIMS 33

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	561,667.82	793.00	OTHER LAB	894.00	0.00
MED/SURG SUPPLY	135,266.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,296.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,308.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37,269.00	7,591.00
EKG/ECG	3,003.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,527.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	202,163.00	1,000.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,560.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,263.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,533.00	1,463.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,911.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,389.00	3,851.00
RADIOLOGY THERAPEUTIC	14,400.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,230.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,366.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,826.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	36,292.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,128.00	0.00			
			TOTAL ANCILLARY	1,206,291.82	14,698.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,206,291.82	14,698.00

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: 09/24/2013  
Run Time: 15:02:35  
Page: 17

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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN  
 550 PEACHTREE ST NE  
 ATLANTA,GA 30308-2247

PROVIDER NUMBER 000000503A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,779,949.37	ADJUSTMENTS	4,595,161.09
COVERED CHARGES	73,730,431.44	CONTRACTUAL ALLOW	48,646,088.18
NON-COVERD CHARGES	2,049,517.93	TOTAL MEDICAID LIAB	25,084,343.26
		LESS: COB	120,874.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,963,469.09

TOTAL NUMBER OF ADMISSIONS 2,181

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,857		0	11,801,677.00		754,042.00
ROUTINE NURSERY	1,093		0	1,135,305.00		325.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11,950		0	12,936,982.00		754,367.00
SPECIAL CARE SERVICES						
CCU	384		0	1,535,480.00		0.00
ICU	1,583		0	6,327,485.00		0.00
NICU	604		0	1,564,790.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,571		0	9,427,755.00		0.00
TOTAL ACCOMODATIONS	14,521		0	22,364,737.00		754,367.00



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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,992,601.30	71,220.23	OTHER LAB	418,460.00	1,067.00
MED/SURG SUPPLY	4,612,447.75	134,828.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,826,478.70	103,635.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,090,074.00	4,143.00	OTHER THERAPEUTIC SVC	0.00	999.00
CT SCAN	2,377,120.00	25,433.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	612,019.00	4,611.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	272,893.00	490.00	MRI SERVICES	1,892,410.00	5,697.00
IV THERAPY	32,439.00	1,820.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,791,936.50	30,299.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,148,934.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,596,504.00	33,935.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,242,808.00	7,495.00	AMBULANCE	0.00	0.00
GI SERVICES	333,266.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,916,134.00	19,262.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	458,910.00	4,260.00	DRUG-SPECIFIC/HOME IV	0.00	116,569.60
LABORATORY PATHOLOGIC	426,706.00	4,017.00	INJECTABLE DRUGS	6,044,922.19	78,341.72
RADIOLOGY THERAPEUTIC	52,738.00	8,439.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	206,188.00	3,788.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	147,116.00	1,116.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,220,050.00	249,388.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	146.00	3,497.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,227,813.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	24,819.00
OTHER IMAGING SERVICE	295,216.00	224,469.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,100,577.00	15,858.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	193,474.00	104,289.86			
AUDIOLOGY	12,668.00	0.00			
CARDIOLOGY	2,580,353.00	3,821.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	142,436.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	99,856.00	7,543.00			
			TOTAL ANCILLARY	51,365,694.44	1,295,150.93
			TOTAL ACCOMODATIONS	22,364,737.00	754,367.00
			TOTAL CHARGES	73,730,431.44	2,049,517.93

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

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

Run Date: 09/24/2013  
Run Time: 15:02:43  
Page: 3

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012233010628	06/07/12 - 06/19/12	08/27/12	0.00	5,697.00	0.00	0.00	0.00
614	2212264010425	08/21/12 - 08/27/12	09/24/12	0.00	2,576.00	0.00	0.00	0.00
614	2212314019817	06/20/12 - 06/28/12	11/19/12	0.00	2,576.00	0.00	0.00	0.00
614	2012321002103	08/03/12 - 08/08/12	11/19/12	0.00	5,697.00	0.00	0.00	0.00
614	2212325011526	05/29/12 - 06/07/12	11/26/12	0.00	5,697.00	0.00	0.00	0.00
614	2213080006587	03/18/12 - 03/23/12	03/25/13	0.00	2,576.00	0.00	0.00	0.00
TOTAL				0.00	24,819.00	0.00	0.00	0.00

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	397,775.17	ADJUSTMENTS	0.00
COVERED CHARGES	391,679.17	CONTRACTUAL ALLOW	210,485.45
NON-COVERD CHARGES	6,096.00	TOTAL MEDICAID LIAB	181,193.72
		LESS: COB	181,193.72
		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	72		0	76,978.00		3,530.00
ROUTINE NURSERY	19		0	22,145.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	91		0	99,123.00		3,530.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	15,980.00		0.00
NICU	1		0	2,575.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	18,555.00		0.00
TOTAL ACCOMODATIONS	96		0	117,678.00		3,530.00

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,046.45	0.00	OTHER LAB	2,965.00	0.00
MED/SURG SUPPLY	18,282.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,841.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,487.00	0.00	OTHER THERAPEUTIC SVC	0.00	999.00
CT SCAN	8,248.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,993.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	708.00	0.00	MRI SERVICES	22,276.00	0.00
IV THERAPY	326.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,092.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	72,099.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,442.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,593.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,845.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,089.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,775.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,436.00	0.00	INJECTABLE DRUGS	5,707.47	0.00
RADIOLOGY THERAPEUTIC	7,612.00	1,455.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,623.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,532.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	112.00			
CARDIOLOGY	14,776.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	207.00	0.00			
			TOTAL ANCILLARY	274,001.17	2,566.00
			TOTAL ACCOMODATIONS	117,678.00	3,530.00
			TOTAL CHARGES	391,679.17	6,096.00

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: 09/24/2013  
Run Time: 15:05:14  
Page: 6

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,628,631.28	ADJUSTMENTS	933,320.97
COVERED CHARGES	23,715,759.38	CONTRACTUAL ALLOW	18,054,813.79
NON-COVERD CHARGES	5,912,871.90	TOTAL MEDICAID LIAB	5,660,945.59
		LESS: COB	8,742.58
		LESS: COPAYMENT	16,344.52
		REIMBURSEMENT	5,635,858.49
		ALL OTHER	3,704,641.00
		FEE SCHEDULE-LAB	517,354.84
		INJECTABLE DRUGS	1,413,862.65

TOTAL NUMBER OF CLAIMS 9,015

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	698,705.44	9,848.30	OTHER LAB	211,607.00	513.00
MED/SURG SUPPLY	725,983.50	43,219.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	6,429.00	EDUCATION & TRAINING	395.00	0.00
RADIOLOGY-DIAGNOSTIC	711,370.00	22,784.00	OTHER THERAPEUTIC SVC	0.00	12,144.00
CT SCAN	1,335,969.00	827,268.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	902.00	13,024.00	FEE SCHEDULE LAB	4,378,022.83	740,556.78
EKG/ECG	242,640.00	1,709.00	MRI SERVICES	1,174,838.00	257,555.00
IV THERAPY	763,327.00	5,820.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,242,837.00	835,671.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	59,126.00	230.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	184,552.00	48,825.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	454,662.00	225.00	AMBULANCE	0.00	0.00
GI SERVICES	77,578.00	63,065.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,240,993.50	150,833.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	536,975.00	1,770.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	4,707.00	INJECTABLE DRUGS	4,213,176.59	1,294,384.89
RADIOLOGY THERAPEUTIC	282,759.00	12,331.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,544.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,685.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	51,490.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,117.00	5,894.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	143,387.00	230,129.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	25,439.00
OTHER IMAGING SERVICE	719,254.00	477,670.00			
BLOOD	129.00	0.00			
BLOOD STORAGE & PRO.	431,384.00	53,851.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	410,288.00	249,346.93			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	570,372.00	436,291.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	689.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	865,720.52	23,620.00			
			TOTAL ANCILLARY	23,715,759.38	5,912,871.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,715,759.38	5,912,871.90

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

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

Run Date: 09/24/2013  
Run Time: 15:05:14  
Page: 8

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212178010264	04/23/12 - 04/23/12	07/02/12	0.00	75.00	0.00	0.00	0.00
614	2012200033865	04/14/12 - 04/14/12	07/23/12	0.00	5,697.00	0.00	0.00	0.00
614	2012212011645	07/18/12 - 07/18/12	08/06/12	0.00	5,697.00	0.00	0.00	0.00
614	2012223022972	07/30/12 - 07/30/12	08/13/12	0.00	5,697.00	0.00	0.00	0.00
614	2012264022263	07/09/12 - 07/09/12	09/24/12	0.00	2,576.00	0.00	0.00	0.00
614	2012272049592	06/28/12 - 06/28/12	10/01/12	0.00	5,697.00	0.00	0.00	0.00
TOTAL				0.00	25,439.00	0.00	0.00	0.00

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

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

Run Date: 09/24/2013  
Run Time: 15:09:30  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	323,813.32	ADJUSTMENTS	0.00
COVERED CHARGES	191,084.04	CONTRACTUAL ALLOW	27,878.79
NON-COVERD CHARGES	132,729.28	TOTAL MEDICAID LIAB	163,205.25
		LESS: COB	162,986.86
		LESS: COPAYMENT	218.39
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 102



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

EMORY UNIVERSITY HOSPITAL MIDTOWN PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 550 PEACHTREE ST NE 000000503A SERVICE DATES 09/01/11 THROUGH 08/31/12  
 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	6,353.18	48.72	OTHER LAB	5,208.00	0.00
MED/SURG SUPPLY	3,965.00	292.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	65.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,805.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,177.00	19,456.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	44,251.00	7,506.00
EKG/ECG	2,242.00	0.00	MRI SERVICES	2,510.00	8,079.00
IV THERAPY	2,771.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,347.00	12,064.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,407.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	262.00	16,104.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,825.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,319.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,573.00	2,352.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,126.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,211.86	63,738.26
RADIOLOGY THERAPEUTIC	4,357.00	331.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	26.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	149.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,231.00	1,248.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,531.00	1,419.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,131.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,332.00	0.00			
			TOTAL ANCILLARY	191,084.04	132,729.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	191,084.04	132,729.28

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: 09/24/2013  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	750,277.83	ADJUSTMENTS	738.15
COVERED CHARGES	652,545.08	CONTRACTUAL ALLOW	598,766.40
NON-COVERD CHARGES	97,732.75	TOTAL MEDICAID LIAB	53,778.68
		LESS: COB	0.00
		LESS: COPAYMENT	2,517.06
		REIMBURSEMENT	51,261.62
		TOTAL NUMBER OF CLAIMS	962

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,386.13	0.00	OTHER LAB	8,371.00	0.00
MED/SURG SUPPLY	4,714.50	6.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,725.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,898.00	45,327.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	130,239.00	26,878.00
EKG/ECG	11,682.00	0.00	MRI SERVICES	21,320.00	11,138.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	224.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,260.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	365,105.50	4,016.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,070.95	2,646.75
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	36.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,200.00	5,156.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,364.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,004.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,345.00	1,165.00			
			TOTAL ANCILLARY	652,545.08	97,732.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	652,545.08	97,732.75

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

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,102.22	ADJUSTMENTS	0.00
COVERED CHARGES	4,102.22	CONTRACTUAL ALLOW	1,691.72
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,410.50
		LESS: COB	2,407.50
		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

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 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	203.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,150.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,139.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.22	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	534.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,102.22	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,102.22	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

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,525,392.06	ADJUSTMENTS	408,421.97
COVERED CHARGES	5,252,218.35	CONTRACTUAL ALLOW	4,126,935.26
NON-COVERD CHARGES	273,173.71	TOTAL MEDICAID LIAB	1,125,283.09
		LESS: COB	0.00
		LESS: COPAYMENT	1,716.00
		REIMBURSEMENT	1,123,567.09
		TOTAL NUMBER OF CLAIMS	214

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,112.35	426.05	OTHER LAB	1,844.00	0.00
MED/SURG SUPPLY	97,546.25	27,320.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,628.00	664.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,213.00	2,098.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	320.00	FEE SCHEDULE LAB	175,508.72	39,074.00
EKG/ECG	472.00	0.00	MRI SERVICES	27,845.00	0.00
IV THERAPY	244,941.00	344.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	167,655.00	8,996.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,456.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,070.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,433.00	98.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,775.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,850,676.03	164,150.66
RADIOLOGY THERAPEUTIC	184,082.00	4,853.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,355.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	144,898.00	2,809.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	946.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,459.00	4,386.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	150,283.00	11,674.00			
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	45,029.00	2,536.00			
			TOTAL ANCILLARY	5,252,218.35	273,173.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,252,218.35	273,173.71

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

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

Run Date: 09/24/2013  
Run Time: 15:10:15  
Page: 17

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,515.81	ADJUSTMENTS	0.00
COVERED CHARGES	26,508.05	CONTRACTUAL ALLOW	10,943.98
NON-COVERD CHARGES	7.76	TOTAL MEDICAID LIAB	15,564.07
		LESS: COB	15,561.07
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1



SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,084.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	224.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	7.76
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	23,108.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,508.05	7.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,508.05	7.76

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,934,412.90	ADJUSTMENTS	62,221.90
COVERED CHARGES	6,819,555.78	CONTRACTUAL ALLOW	3,813,308.66
NON-COVERD CHARGES	114,857.12	TOTAL MEDICAID LIAB	3,006,247.12
		LESS: COB	48,472.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,957,774.67

TOTAL NUMBER OF ADMISSIONS 494

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,782		0	1,065,950.00		32,790.00
ROUTINE NURSERY	51		0	31,110.00		12,158.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		15.00
TOTAL ROUTINE	1,833		0	1,097,060.00		44,963.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	568		0	715,170.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	568		0	715,170.00		0.00
TOTAL ACCOMODATIONS	2,401		0	1,812,230.00		44,963.00

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

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

Run Date: 09/24/2013  
 Run Time: 15:10:27  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	533,964.55	30.30	OTHER LAB	27,724.00	0.00
MED/SURG SUPPLY	438,905.72	15,288.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,093,657.09	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	131,820.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	482,013.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,790.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	61,256.50	0.00	MRI SERVICES	45,634.50	0.00
IV THERAPY	69,418.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	267,810.50	1,545.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,249.59	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	173,843.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,304.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	194,665.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,508.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,201.50	0.00	INJECTABLE DRUGS	915,782.33	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,761.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,000.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	27,151.50	3,584.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,476.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,274.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,000.50
OTHER IMAGING SERVICE	43,483.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	83,479.50	40,825.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	39,664.00	4,145.00			
AUDIOLOGY	3,612.00	0.00			
CARDIOLOGY	123,311.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,406.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	633.60	0.00			
			TOTAL ANCILLARY	5,007,325.78	69,894.12
			TOTAL ACCOMODATIONS	1,812,230.00	44,963.00
			TOTAL CHARGES	6,819,555.78	114,857.12

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012198029599	05/05/12 - 05/13/12	07/23/12	0.00	3,000.50	0.00	0.00	0.00
TOTAL				0.00	3,000.50	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: 09/24/2013  
 Run Time: 15:11:05  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,752.38	ADJUSTMENTS	0.00
COVERED CHARGES	41,397.38	CONTRACTUAL ALLOW	4,233.52
NON-COVERD CHARGES	355.00	TOTAL MEDICAID LIAB	37,163.86
		LESS: COB	37,163.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	1,770.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	1,770.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	1,770.00		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: 09/24/2013  
 Run Time: 15:11:05  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	265.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,795.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	935.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	154.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	519.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	374.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,450.00	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	516.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	66.00	0.00	INJECTABLE DRUGS	1,275.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	255.50	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	23,600.50	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.	767.00	355.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	39,627.38	355.00
			TOTAL ACCOMODATIONS	1,770.00	0.00
			TOTAL CHARGES	41,397.38	355.00

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: 09/24/2013  
Run Time: 15:11:07  
Page: 6

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,794,570.64	ADJUSTMENTS	186,889.71
COVERED CHARGES	4,784,747.15	CONTRACTUAL ALLOW	3,555,111.64
NON-COVERD CHARGES	1,009,823.49	TOTAL MEDICAID LIAB	1,229,635.51
		LESS: COB	248.69
		LESS: COPAYMENT	5,463.73
		REIMBURSEMENT	1,223,923.09
		ALL OTHER	845,446.58
		FEE SCHEDULE-LAB	166,123.02
		INJECTABLE DRUGS	212,353.49
		TOTAL NUMBER OF CLAIMS	4,618

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,914.54	41,873.77	OTHER LAB	170,053.00	415.50
MED/SURG SUPPLY	158,210.68	8,082.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	400.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	258,260.00	6,454.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	495,079.00	383,631.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,852.00	10,445.50	FEE SCHEDULE LAB	1,316,633.54	227,260.80
EKG/ECG	52,492.50	1,000.00	MRI SERVICES	166,786.50	17,879.00
IV THERAPY	111,911.00	13,763.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	363,235.84	121,483.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	824.00	337.83	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,441.50	1,790.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,047.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	392,223.00	16,266.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,571.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	466.00	INJECTABLE DRUGS	449,766.72	78,550.54
RADIOLOGY THERAPEUTIC	33,044.50	2,455.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,280.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	927.50	1,411.50	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	22,289.00	7,423.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,767.05	14,436.67
LITHOTRIPSY	50,712.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	154,785.50	12,637.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,183.50	10,707.00			
ONCOLOGY	1,026.00	85.50			
NUCLEAR MEDICINE	195,005.50	26,820.00			
AUDIOLOGY	150.50	0.00			
CARDIOLOGY	90,220.50	1,268.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,505.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,546.78	2,477.53			
			TOTAL ANCILLARY	4,784,747.15	1,009,823.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,784,747.15	1,009,823.49



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: 09/24/2013  
Run Time: 15:13:03  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,293.95	ADJUSTMENTS	0.00
COVERED CHARGES	65,541.28	CONTRACTUAL ALLOW	20,196.25
NON-COVERD CHARGES	23,752.67	TOTAL MEDICAID LIAB	45,345.03
		LESS: COB	45,241.20
		LESS: COPAYMENT	103.83
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 79

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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512.22	794.67	OTHER LAB	2,318.50	0.00
MED/SURG SUPPLY	1,428.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,414.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,306.00	15,940.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,679.50	0.00	FEE SCHEDULE LAB	22,337.50	4,369.50
EKG/ECG	250.00	0.00	MRI SERVICES	4,251.00	0.00
IV THERAPY	1,201.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,547.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,065.00	351.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	583.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,914.00	408.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	520.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,473.08	786.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,315.00	603.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,005.00	500.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,419.95	0.00			
			TOTAL ANCILLARY	65,541.28	23,752.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,541.28	23,752.67

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

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

Run Date: 09/24/2013  
Run Time: 15:13:08  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	210,005.60	ADJUSTMENTS	1,623.75
COVERED CHARGES	183,511.92	CONTRACTUAL ALLOW	167,989.51
NON-COVERD CHARGES	26,493.68	TOTAL MEDICAID LIAB	15,522.41
		LESS: COB	50.00
		LESS: COPAYMENT	501.02
		REIMBURSEMENT	14,971.39
		TOTAL NUMBER OF CLAIMS	278

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

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

Run Date: 09/24/2013  
 Run Time: 15:13:08  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL  
 902 N 7TH ST  
 CORDELE, GA 31015-3234

PROVIDER NUMBER  
 000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	739.08	350.29	OTHER LAB	2,184.00	0.00
MED/SURG SUPPLY	2,169.00	119.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,612.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,335.75	21,825.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	65,473.50	1,715.50
EKG/ECG	4,250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,838.50	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	351.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,575.00	927.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,542.34	1,556.89
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	167.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,147.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,127.25	0.00			
			TOTAL ANCILLARY	183,511.92	26,493.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	183,511.92	26,493.68

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,916.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,916.50	CONTRACTUAL ALLOW	714.48
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,202.02
		LESS: COB	1,199.02
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	1,095.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	501.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,916.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,916.50	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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,865.23	ADJUSTMENTS	4,787.74
COVERED CHARGES	78,518.25	CONTRACTUAL ALLOW	40,192.33
NON-COVERD CHARGES	346.98	TOTAL MEDICAID LIAB	38,325.92
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	38,301.92

TOTAL NUMBER OF CLAIMS 8

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82.40	198.48	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	572.50	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	441.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,005.50	148.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	73,226.85	0.00
RADIOLOGY THERAPEUTIC	689.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	501.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,518.25	346.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,518.25	346.98



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

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

Run Date: 09/24/2013  
Run Time: 15:13:16  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:13:26  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	940,887.33	ADJUSTMENTS	0.00
COVERED CHARGES	753,202.33	CONTRACTUAL ALLOW	488,404.58
NON-COVERD CHARGES	187,685.00	TOTAL MEDICAID LIAB	264,797.75
		LESS: COB	15,168.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	249,629.58

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	214		0	145,520.00		187,250.00
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	214		0	145,520.00		187,250.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	58		0	105,096.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	58		0	105,096.00		0.00
TOTAL ACCOMODATIONS	272		0	250,616.00		187,250.00

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

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

Run Date: 09/24/2013  
 Run Time: 15:13:26  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,032.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35,356.66	435.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	51,181.45	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,303.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,390.82	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	307.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,060.52	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	244,096.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,570.70	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	391.74	0.00	INJECTABLE DRUGS	56,706.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	15,265.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,994.90	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,052.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	888.95	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	987.00	0.00			
			TOTAL ANCILLARY	502,586.33	435.00
			TOTAL ACCOMODATIONS	250,616.00	187,250.00
			TOTAL CHARGES	753,202.33	187,685.00

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

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 07/01/11 THROUGH 06/30/12  
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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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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
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	07/01/11	THROUGH	06/30/12
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	07/01/11	THROUGH	06/30/12
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	07/01/11	THROUGH	06/30/12
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

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	07/01/11	THROUGH	06/30/12
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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,468,932.04	ADJUSTMENTS	2,272,919.49
COVERED CHARGES	53,219,822.50	CONTRACTUAL ALLOW	32,468,789.12
NON-COVERD CHARGES	1,249,109.54	TOTAL MEDICAID LIAB	20,751,033.38
		LESS: COB	209,446.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,541,586.40
		TOTAL NUMBER OF ADMISSIONS	3,730

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,834		0	7,889,393.00		681,578.00
ROUTINE NURSERY	3,085		0	2,380,112.00		37,119.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,919		0	10,269,505.00		718,697.00
SPECIAL CARE SERVICES						
CCU	1		0	1,856.00		0.00
ICU	1,663		0	2,899,518.00		0.00
NICU	548		0	1,007,970.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		159	0.00		136,737.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,212		159	3,909,344.00		136,737.00
TOTAL ACCOMODATIONS	16,131		159	14,178,849.00		855,434.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,848,550.43	5,826.60	OTHER LAB	665,317.16	831.00
MED/SURG SUPPLY	1,480,907.45	12,035.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,181,651.14	15,149.10	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,063,616.80	928.05	OTHER THERAPEUTIC SVC	0.00	24,225.72
CT SCAN	1,637,507.65	63,920.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	474,649.41	996.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	431,805.37	307.05	MRI SERVICES	394,481.00	0.00
IV THERAPY	510,400.02	8,435.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,319,963.71	10,936.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,180,801.36	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,836,217.59	27,093.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	524,411.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	211,881.84	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,536,645.06	4,119.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,037,010.41	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,670.00
LABORATORY PATHOLOGIC	318,432.26	0.00	INJECTABLE DRUGS	5,451,139.46	45,576.00
RADIOLOGY THERAPEUTIC	136,902.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	169,281.77	301.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	196,340.60	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	172,341.00	20,622.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	298.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	144,942.80	0.00	IMPL DEV CHARGE PATIENTS	959,684.77	343.00
LITHOTRIpsy	17,987.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	576,916.05	690.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	665,882.00	36,571.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	394,518.90	94,436.65			
AUDIOLOGY	120,644.05	0.00			
CARDIOLOGY	1,147,752.35	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,273.85	0.00			
ORGAN ACQUISITION	0.00	297.00			
TREATMENT/OBSERV. RM	183,818.93	14,363.45			
			TOTAL ANCILLARY	39,040,973.50	393,675.54
			TOTAL ACCOMODATIONS	14,178,849.00	855,434.00
			TOTAL CHARGES	53,219,822.50	1,249,109.54

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,064,603.43	ADJUSTMENTS	0.00
COVERED CHARGES	1,061,636.59	CONTRACTUAL ALLOW	296,220.96
NON-COVERD CHARGES	2,966.84	TOTAL MEDICAID LIAB	765,415.63
		LESS: COB	765,415.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	71		0	51,972.00		1,362.00
ROUTINE NURSERY	102		0	154,351.00		788.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	173		0	206,323.00		2,150.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	143		0	285,606.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	143		0	285,606.00		0.00
TOTAL ACCOMODATIONS	316		0	491,929.00		2,150.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,232.30	0.00	OTHER LAB	3,407.76	0.00
MED/SURG SUPPLY	16,993.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	87,935.07	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,339.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,715.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,365.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	921.15	0.00	MRI SERVICES	2,395.00	0.00
IV THERAPY	749.76	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,660.86	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,858.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	146,387.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,006.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,983.11	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,264.93	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,809.00	0.00	INJECTABLE DRUGS	58,615.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	315.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,903.05	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3.10	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,783.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,257.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,135.00	768.89			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,058.00	44.85			
AUDIOLOGY	1,657.20	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	3,716.78	0.00			
			TOTAL ANCILLARY	569,707.59	816.84
			TOTAL ACCOMODATIONS	491,929.00	2,150.00
			TOTAL CHARGES	1,061,636.59	2,966.84

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

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

Run Date: 09/24/2013  
Run Time: 15:15:17  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,917,296.94	ADJUSTMENTS	1,568,714.25
COVERED CHARGES	18,284,199.07	CONTRACTUAL ALLOW	14,308,398.72
NON-COVERD CHARGES	2,633,097.87	TOTAL MEDICAID LIAB	3,975,800.35
		LESS: COB	8,378.63
		LESS: COPAYMENT	7,987.74
		REIMBURSEMENT	3,959,433.98
		ALL OTHER	3,447,850.94
		FEE SCHEDULE-LAB	314,851.96
		INJECTABLE DRUGS	196,731.08
		TOTAL NUMBER OF CLAIMS	7,905

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

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

Run Date: 09/24/2013  
 Run Time: 15:15:17  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363,432.56	30,446.00	OTHER LAB	582,597.96	9,165.20
MED/SURG SUPPLY	415,020.83	31,413.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	157.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	814,770.20	19,710.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,150,038.95	262,088.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,974.74	16,931.01	FEE SCHEDULE LAB	3,157,082.27	644,573.25
EKG/ECG	347,093.36	5,955.75	MRI SERVICES	349,154.00	35,669.75
IV THERAPY	592,792.06	37,970.12	PROFESSIONAL FEES	0.00	29.00
OPERATING ROOM	1,401,517.70	307,730.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	467,993.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,128.38	16,313.41	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	323,068.17	2,120.00	AMBULANCE	0.00	0.00
GI SERVICES	59,098.35	11,655.53	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,957,692.11	20,016.74	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	689,807.58	6,271.00	DRUG-SPECIFIC/HOME IV	2,646.00	1,701.00
LABORATORY PATHOLOGIC	0.00	200.00	INJECTABLE DRUGS	842,483.50	307,049.75
RADIOLOGY THERAPEUTIC	421,001.80	8,721.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,340.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,707.25	3,809.20	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	48,575.28	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34,136.19	2,169.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	78,300.40	0.00	IMPL DEV CHARGE PATIENTS	45,312.50	319,345.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	207.00
OTHER IMAGING SERVICE	1,318,922.65	198,089.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,993.00	23,371.18			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	300,518.84	116,622.80			
AUDIOLOGY	4,484.15	3,322.70			
CARDIOLOGY	472,171.66	111,818.13			
AMBULATORY SURGERY	925.75	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,649.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	869,683.21	27,347.36			
			TOTAL ANCILLARY	18,284,199.07	2,632,905.87
			TOTAL ACCOMODATIONS	0.00	192.00
			TOTAL CHARGES	18,284,199.07	2,633,097.87



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: 09/24/2013  
Run Time: 15:15:17  
Page: 7

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1112053002422	02/02/12 - 02/02/12	03/19/12	0.00	57.00	0.00	0.00	0.00
618	1112053002422	02/02/12 - 02/02/12	03/19/12	0.00	150.00	0.00	0.00	0.00
TOTAL				0.00	207.00	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: 09/24/2013  
Run Time: 15:18:03  
Page: 8

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	233,407.00	ADJUSTMENTS	0.00
COVERED CHARGES	173,977.18	CONTRACTUAL ALLOW	100,254.71
NON-COVERD CHARGES	59,429.82	TOTAL MEDICAID LIAB	73,722.47
		LESS: COB	73,698.47
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 77

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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,156.60	3,495.90	OTHER LAB	2,394.92	0.00
MED/SURG SUPPLY	3,640.50	124.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,206.63	340.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,154.25	12,433.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	43,293.83	8,357.42
EKG/ECG	4,960.50	577.05	MRI SERVICES	0.00	1,497.00
IV THERAPY	7,173.15	946.42	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,779.58	6,688.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,605.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,208.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,644.56	210.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,718.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,093.80	3,419.70
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	615.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	674.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,713.00	11,832.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,814.00	1,730.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,042.00	5,453.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,546.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,216.96	1,650.00			
			TOTAL ANCILLARY	173,977.18	59,429.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	173,977.18	59,429.82

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

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

Run Date: 09/24/2013  
Run Time: 15:18:07  
Page: 10

DEKALB MEDICAL CENTER  
2701 N DECATUR RD  
DECATUR,GA 30033-5918

PROVIDER NUMBER  
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,706,366.07	ADJUSTMENTS	8,810.09
COVERED CHARGES	1,561,207.12	CONTRACTUAL ALLOW	1,488,932.67
NON-COVERD CHARGES	145,158.95	TOTAL MEDICAID LIAB	72,274.45
		LESS: COB	18.90
		LESS: COPAYMENT	2,571.21
		REIMBURSEMENT	69,684.34
		TOTAL NUMBER OF CLAIMS	1,292

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

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

Run Date: 09/24/2013  
 Run Time: 15:18:07  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,543.80	2,685.50	OTHER LAB	28,521.09	2,431.92
MED/SURG SUPPLY	15,733.00	1,470.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	102.00
RADIOLOGY-DIAGNOSTIC	68,005.63	203.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	86,455.35	16,320.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	417.50	FEE SCHEDULE LAB	386,948.39	69,153.70
EKG/ECG	32,532.00	307.05	MRI SERVICES	12,806.00	2,912.00
IV THERAPY	56,320.00	2,441.89	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	198.00	3,910.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,206.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,874.10	753.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,133.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	680,179.35	1,023.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,216.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,863.60	5,885.10
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	292.95	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,675.36	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	12,356.00	0.00	IMPL DEV CHARGE PATIENTS	150.00	95.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	86,575.00	32,749.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,068.00	261.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,726.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22,794.92	0.00			
			TOTAL ANCILLARY	1,561,207.12	145,090.95
			TOTAL ACCOMODATIONS	0.00	68.00
			TOTAL CHARGES	1,561,207.12	145,158.95

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,042.30	ADJUSTMENTS	0.00
COVERED CHARGES	9,599.60	CONTRACTUAL ALLOW	6,638.71
NON-COVERD CHARGES	2,442.70	TOTAL MEDICAID LIAB	2,960.89
		LESS: COB	2,954.89
		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: 09/24/2013  
 Run Time: 15:18:26  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	75.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	113.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	177.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	995.00	995.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,720.90	830.70
EKG/ECG	270.00	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	3,643.70	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	4.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	467.00	542.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,599.60	2,442.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,599.60	2,442.70

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER  
2701 N DECATUR RD  
DECATUR,GA 30033-5918

PROVIDER NUMBER  
000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,666,405.14	ADJUSTMENTS	121,054.92
COVERED CHARGES	1,571,043.90	CONTRACTUAL ALLOW	1,256,204.94
NON-COVERD CHARGES	95,361.24	TOTAL MEDICAID LIAB	314,838.96
		LESS: COB	0.00
		LESS: COPAYMENT	678.00
		REIMBURSEMENT	314,160.96
		TOTAL NUMBER OF CLAIMS	62



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,702.40	990.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	78,458.00	2,472.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,765.50	3,363.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,230.00	1,154.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,157.46	FEE SCHEDULE LAB	34,962.29	1,196.35
EKG/ECG	2,885.25	540.00	MRI SERVICES	0.00	0.00
IV THERAPY	79,469.78	573.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	151,727.68	48,533.78	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	35,992.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,205.62	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,442.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	700,483.20	16,391.60
RADIOLOGY THERAPEUTIC	301,931.96	1,860.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	14,500.00	9,668.00
LITHOTRIPSY	36,423.68	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,726.00	1,506.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,814.00	502.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,023.00	5,453.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,647.62	0.00			
			TOTAL ANCILLARY	1,571,043.90	95,361.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,571,043.90	95,361.24

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: 09/24/2013  
Run Time: 15:18:33  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:18:43  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,422,452.39	ADJUSTMENTS	432,511.29
COVERED CHARGES	12,108,791.14	CONTRACTUAL ALLOW	7,469,163.63
NON-COVERD CHARGES	313,661.25	TOTAL MEDICAID LIAB	4,639,627.51
		LESS: COB	30,472.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,609,154.53

TOTAL NUMBER OF ADMISSIONS 559

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,744		0	2,007,803.00		242,608.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,744		0	2,007,803.00		242,608.00
SPECIAL CARE SERVICES						
CCU	5		0	4,321.00		0.00
ICU	452		0	839,216.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	457		0	843,537.00		0.00
TOTAL ACCOMODATIONS	3,201		0	2,851,340.00		242,608.00

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

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

Run Date: 09/24/2013  
 Run Time: 15:18:43  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE  
 2801 DEKALB MEDICAL PKWY  
 LITHONIA,GA 30058-4996

PROVIDER NUMBER  
 000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	967,620.49	0.00	OTHER LAB	73,179.20	0.00
MED/SURG SUPPLY	258,797.59	1,783.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,952,627.65	1,388.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	295,906.23	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	601,934.91	6,508.19	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	78,570.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	112,461.30	0.00	MRI SERVICES	84,312.00	0.00
IV THERAPY	321,339.68	1,334.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	342,954.05	2,964.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	865,273.00	1,800.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	90,123.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	66,627.25	1,284.33	CAST ROOM	0.00	0.00
EMERGENCY ROOM	518,277.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,034.07	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,536.00
LABORATORY PATHOLOGIC	57,897.09	0.00	INJECTABLE DRUGS	1,615,589.16	2,625.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,544.60	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,127.85	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	82,488.00	10,311.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,475.45	150.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	12,017.00	0.00	IMPL DEV CHARGE PATIENTS	46,731.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	131,672.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	221,814.00	10,685.01			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,527.00	25,683.05			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	227,325.96	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,624.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,579.59	0.00			
			TOTAL ANCILLARY	9,257,451.14	71,053.25
			TOTAL ACCOMODATIONS	2,851,340.00	242,608.00
			TOTAL CHARGES	12,108,791.14	313,661.25

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

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

Run Date: 09/24/2013  
Run Time: 15:19:05  
Page: 3

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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 15:19:06  
Page: 4

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,858,619.45	ADJUSTMENTS	641,062.71
COVERED CHARGES	7,886,914.78	CONTRACTUAL ALLOW	5,990,886.01
NON-COVERD CHARGES	971,704.67	TOTAL MEDICAID LIAB	1,896,028.77
		LESS: COB	1,838.33
		LESS: COPAYMENT	2,300.44
		REIMBURSEMENT	1,891,890.00
		ALL OTHER	1,721,622.88
		FEE SCHEDULE-LAB	149,714.34
		INJECTABLE DRUGS	20,552.78

TOTAL NUMBER OF CLAIMS 4,474

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,871.59	9,325.80	OTHER LAB	89,936.40	1,036.92
MED/SURG SUPPLY	151,739.25	8,795.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	49.45	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	514,917.64	5,314.85	OTHER THERAPEUTIC SVC	0.00	199.00
CT SCAN	662,761.35	177,262.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,507.84	9,680.16	FEE SCHEDULE LAB	1,591,690.86	322,136.13
EKG/ECG	162,992.70	1,228.20	MRI SERVICES	112,623.00	18,418.95
IV THERAPY	435,997.02	39,606.39	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	261,458.70	111,197.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,289.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,014.00	10,809.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	144,060.49	2,627.86	AMBULANCE	0.00	0.00
GI SERVICES	76,326.62	19,400.26	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,157,120.95	7,358.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	150,072.67	205.71	DRUG-SPECIFIC/HOME IV	567.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	116,805.50	57,160.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	436.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	253.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	6,069.72	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,986.05	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	32,368.00	0.00	IMPL DEV CHARGE PATIENTS	17,303.00	9,306.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	256.00
OTHER IMAGING SERVICE	484,122.85	110,414.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,504.00	2,290.78			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	95,708.30	22,194.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	100,888.68	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,597.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	352,232.97	16,502.67			
			TOTAL ANCILLARY	7,886,914.78	971,086.67
			TOTAL ACCOMODATIONS	0.00	618.00
			TOTAL CHARGES	7,886,914.78	971,704.67

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5911241000813	07/21/11 - 07/21/11	09/05/11	0.00	256.00	0.00	0.00	0.00
TOTAL				0.00	256.00	0.00	0.00	0.00



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

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

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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,773.56	ADJUSTMENTS	0.00
COVERED CHARGES	73,401.96	CONTRACTUAL ALLOW	35,615.82
NON-COVERD CHARGES	12,371.60	TOTAL MEDICAID LIAB	37,786.14
		LESS: COB	37,771.14
		LESS: COPAYMENT	15.00
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,149.60	0.00	OTHER LAB	1,166.00	0.00
MED/SURG SUPPLY	617.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,581.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,605.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,021.86	4,456.60
EKG/ECG	1,461.15	0.00	MRI SERVICES	0.00	2,386.00
IV THERAPY	6,275.55	1,084.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	758.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	913.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,196.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,427.80	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	641.50	1,472.70
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	300.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,458.00	2,972.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,829.65	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	73,401.96	12,371.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,401.96	12,371.60

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,119,221.25	ADJUSTMENTS	5,072.34
COVERED CHARGES	1,045,206.91	CONTRACTUAL ALLOW	986,078.33
NON-COVERD CHARGES	74,014.34	TOTAL MEDICAID LIAB	59,128.58
		LESS: COB	0.00
		LESS: COPAYMENT	1,695.08
		REIMBURSEMENT	57,433.50
		TOTAL NUMBER OF CLAIMS	1,057

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,279.80	1,542.30	OTHER LAB	7,953.00	1,042.00
MED/SURG SUPPLY	6,241.00	703.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,335.02	276.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,033.50	13,567.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	238,059.38	33,003.90
EKG/ECG	15,013.90	0.00	MRI SERVICES	9,860.00	1,564.00
IV THERAPY	49,672.32	2,836.39	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	918.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	444.00	290.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	385.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	534,452.52	235.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,740.60	2,091.20
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	39.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,525.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	51,057.00	16,776.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,193.70	47.15			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,042.92	0.00			
			TOTAL ANCILLARY	1,045,206.91	74,014.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,045,206.91	74,014.34

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: 09/24/2013  
Run Time: 15:20:56  
Page: 11

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,729.18	ADJUSTMENTS	0.00
COVERED CHARGES	13,397.23	CONTRACTUAL ALLOW	8,783.80
NON-COVERD CHARGES	1,331.95	TOTAL MEDICAID LIAB	4,613.43
		LESS: COB	4,610.43
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.30	125.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	69.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	709.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,948.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,499.52	664.95
EKG/ECG	270.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	460.51	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,934.20	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	14.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	467.00	542.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,397.23	1,331.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,397.23	1,331.95

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: 09/24/2013  
Run Time: 15:20:57  
Page: 13

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	166,939.58	ADJUSTMENTS	20,638.04
COVERED CHARGES	161,761.88	CONTRACTUAL ALLOW	125,619.06
NON-COVERD CHARGES	5,177.70	TOTAL MEDICAID LIAB	36,142.82
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	36,118.82

TOTAL NUMBER OF CLAIMS 7

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,100.10	1,533.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,914.50	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,239.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	710.00	FEE SCHEDULE LAB	7,328.75	1,667.60
EKG/ECG	307.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,039.92	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,894.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	805.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,695.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,873.90	746.30
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	152.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,883.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	536.00	238.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,242.00	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	6,901.44	0.00			
			TOTAL ANCILLARY	161,761.88	5,177.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	161,761.88	5,177.70



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: 09/24/2013  
Run Time: 15:20:59  
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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,020,528.98	ADJUSTMENTS	6,420,004.69
COVERED CHARGES	64,468,017.62	CONTRACTUAL ALLOW	51,995,400.16
NON-COVERD CHARGES	1,552,511.36	TOTAL MEDICAID LIAB	12,472,617.46
		LESS: COB	54,358.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,418,259.33

TOTAL NUMBER OF ADMISSIONS 770

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,592	0	1,437,532.00	666,891.00
ROUTINE NURSERY	250	0	309,360.00	91,485.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,842	0	1,746,892.00	758,376.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,511	0	3,258,062.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	1,047	0	5,941,915.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	78	0.00	97,076.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	2,558	78	9,199,977.00	97,076.00
TOTAL ACCOMODATIONS	4,400	78	10,946,869.00	855,452.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,484,605.37	110,478.31	OTHER LAB	253,264.73	0.00
MED/SURG SUPPLY	7,476,908.14	92,643.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,397,815.89	19,277.17	EDUCATION & TRAINING	63.74	0.00
RADIOLOGY-DIAGNOSTIC	691,716.74	0.00	OTHER THERAPEUTIC SVC	0.00	85.85
CT SCAN	744,765.93	205,998.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	231,304.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	203,371.81	0.00	MRI SERVICES	143,453.96	0.00
IV THERAPY	68,740.16	1,235.56	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,682,384.70	5,158.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	80,618.58	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,712,147.78	1,835.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	181,234.81	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	548,386.32	4,724.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,071,255.22	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	194,001.29	0.00	INJECTABLE DRUGS	11,045,774.94	148,297.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	209,456.81	1,002.76	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,775.72	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	271,217.02	24,119.10	PATIENT CONVENIENCE	0.00	3,284.86
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,592.10	30,544.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	708,527.86	0.00
LITHOTRIPSY	18,946.26	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	261,732.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	850,666.83	4,043.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	191,179.33	36,100.86			
AUDIOLOGY	0.00	8,228.51			
CARDIOLOGY	699,782.18	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,503.83	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,954.36	0.00			
			TOTAL ANCILLARY	53,521,148.62	697,059.36
			TOTAL ACCOMODATIONS	10,946,869.00	855,452.00
			TOTAL CHARGES	64,468,017.62	1,552,511.36

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	173,768.81	ADJUSTMENTS	0.00
COVERED CHARGES	168,698.97	CONTRACTUAL ALLOW	104,948.39
NON-COVERD CHARGES	5,069.84	TOTAL MEDICAID LIAB	63,750.58
		LESS: COB	63,750.58
		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	7,836.00		4,639.00
ROUTINE NURSERY	3		0	2,748.00		339.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	10,584.00		4,978.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,344.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,344.00		0.00
TOTAL ACCOMODATIONS	13		0	12,928.00		4,978.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,675.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,664.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,959.82	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	822.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,349.24	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	33,761.02	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,748.89	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,162.41	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	4,976.27	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,368.64	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,984.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,732.37	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	91.84			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,564.52	0.00			
			TOTAL ANCILLARY	155,770.97	91.84
			TOTAL ACCOMODATIONS	12,928.00	4,978.00
			TOTAL CHARGES	168,698.97	5,069.84

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

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

Run Date: 09/24/2013  
Run Time: 15:22:04  
Page: 5

DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,664,637.41	ADJUSTMENTS	97,634.36
COVERED CHARGES	10,104,623.90	CONTRACTUAL ALLOW	7,958,910.35
NON-COVERD CHARGES	1,560,013.51	TOTAL MEDICAID LIAB	2,145,713.55
		LESS: COB	11,585.28
		LESS: COPAYMENT	5,445.58
		REIMBURSEMENT	2,128,682.69
		ALL OTHER	1,991,329.44
		FEE SCHEDULE-LAB	84,198.58
		INJECTABLE DRUGS	53,154.67

TOTAL NUMBER OF CLAIMS 4,537

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267,823.44	1,670.94	OTHER LAB	40,513.45	2,902.70
MED/SURG SUPPLY	750,539.49	6,099.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	8,611.79	0.00
RADIOLOGY-DIAGNOSTIC	458,908.06	2,317.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	714,409.18	76,981.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,234.38	45,572.01	FEE SCHEDULE LAB	782,615.31	156,246.61
EKG/ECG	157,431.53	1,063.76	MRI SERVICES	94,487.78	10,266.48
IV THERAPY	206,480.83	56,328.03	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,998,516.57	745,271.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	122,169.91	68,794.49	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65,866.34	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	266,151.63	50,518.11	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,642,137.99	28,227.41	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	691,900.91	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	318,085.22	66,881.07
RADIOLOGY THERAPEUTIC	204,380.81	1,159.49	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,598.76	13,817.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	52.92
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	160,850.33	1,186.85	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,589.36	6,062.99
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	325,901.49	12,473.39			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	21,960.16	3,313.07			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	297,349.58	91,357.04			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	135,831.16	34,968.53			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,785.51	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	250,492.93	76,481.24			
			TOTAL ANCILLARY	10,104,623.90	1,560,013.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,104,623.90	1,560,013.51

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

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	336,198.15	ADJUSTMENTS	0.00
COVERED CHARGES	218,544.10	CONTRACTUAL ALLOW	152,652.11
NON-COVERD CHARGES	117,654.05	TOTAL MEDICAID LIAB	65,891.99
		LESS: COB	65,832.98
		LESS: COPAYMENT	59.01
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 91



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

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,217.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,390.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,726.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,284.46	28,159.74	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	685.86	FEE SCHEDULE LAB	15,495.58	3,496.32
EKG/ECG	1,661.43	0.00	MRI SERVICES	0.00	8,927.94
IV THERAPY	11,021.61	312.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,912.18	41,223.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	1,610.40	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	788.12	3,446.46	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,282.09	17,836.07	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,655.82	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,284.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,190.51	4,061.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,154.20	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,465.86	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,519.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,999.94	1,860.02			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,249.10	2,359.94			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,145.82	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	773.20	0.00			
			TOTAL ANCILLARY	218,544.10	117,654.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	218,544.10	117,654.05

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

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

Run Date: 09/24/2013  
Run Time: 15:24:24  
Page: 9

DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	482,965.82	ADJUSTMENTS	600.34
COVERED CHARGES	467,450.96	CONTRACTUAL ALLOW	440,543.82
NON-COVERD CHARGES	15,514.86	TOTAL MEDICAID LIAB	26,907.14
		LESS: COB	47.72
		LESS: COPAYMENT	810.01
		REIMBURSEMENT	26,049.41
		TOTAL NUMBER OF CLAIMS	481

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,518.94	0.00	OTHER LAB	0.00	1,198.97
MED/SURG SUPPLY	8,280.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,601.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,535.48	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,157.94	8,049.23
EKG/ECG	11,569.78	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,197.83	633.39	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,330.29	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	332,386.59	635.38	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	12,091.61	3,135.70
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	12,410.05	1,009.99			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	852.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	370.66	0.00			
			TOTAL ANCILLARY	467,450.96	15,514.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	467,450.96	15,514.86

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: 09/24/2013  
Run Time: 15:24:37  
Page: 11

DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,430.86	ADJUSTMENTS	0.00
COVERED CHARGES	17,423.22	CONTRACTUAL ALLOW	12,367.92
NON-COVERD CHARGES	1,007.64	TOTAL MEDICAID LIAB	5,055.30
		LESS: COB	5,052.30
		LESS: COPAYMENT	3.00
		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: 09/24/2013  
 Run Time: 15:24:37  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	324.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	244.24	205.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,623.19	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,811.24	36.25
EKG/ECG	553.81	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,956.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,210.87	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93.04	440.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	930.01	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,423.22	1,007.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,423.22	1,007.64

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: 09/24/2013  
Run Time: 15:24:39  
Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,500,076.82	ADJUSTMENTS	35,338.79
COVERED CHARGES	2,378,918.39	CONTRACTUAL ALLOW	1,965,653.32
NON-COVERD CHARGES	121,158.43	TOTAL MEDICAID LIAB	413,265.07
		LESS: COB	0.00
		LESS: COPAYMENT	486.00
		REIMBURSEMENT	412,779.07
		TOTAL NUMBER OF CLAIMS	81

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

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,392.63	0.00	OTHER LAB	1,165.91	0.00
MED/SURG SUPPLY	289,979.40	297.81	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,422.46	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,452.35	2,529.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	323.69	553.04	FEE SCHEDULE LAB	40,816.28	4,738.25
EKG/ECG	2,171.38	0.00	MRI SERVICES	4,847.87	0.00
IV THERAPY	3,693.81	938.73	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,155,380.39	85,583.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,252.27	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	5,568.19	312.91	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	366,259.87	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,649.74	3,301.09
RADIOLOGY THERAPEUTIC	351,039.36	4,956.91	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	298.88	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,713.96	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,278.59	11,844.02
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,511.19	4,837.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,105.16	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	886.46			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,893.89	79.05			
			TOTAL ANCILLARY	2,378,918.39	121,158.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,378,918.39	121,158.43

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

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

Run Date: 09/24/2013  
Run Time: 15:24:43  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
000000558A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/11	THROUGH	03/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



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

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER 000000591A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,502,810.70	ADJUSTMENTS	52,581.56
COVERED CHARGES	2,401,546.74	CONTRACTUAL ALLOW	1,168,473.82
NON-COVERD CHARGES	101,263.96	TOTAL MEDICAID LIAB	1,233,072.92
		LESS: COB	20,515.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,212,557.20
		TOTAL NUMBER OF ADMISSIONS	210

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	621		0	385,400.00		74,800.00
ROUTINE NURSERY	53		0	21,730.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,400.00
TOTAL ROUTINE	674		0	407,130.00		76,200.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	105		0	144,375.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	105		0	144,375.00		0.00
TOTAL ACCOMODATIONS	779		0	551,505.00		76,200.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	339,721.55	0.00	OTHER LAB	8,547.32	0.00
MED/SURG SUPPLY	266,474.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	400,055.29	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,054.62	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	96,717.45	13,720.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,140.38	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	30,883.56	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	37,296.67	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	120,002.62	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,602.84	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,102.57	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	63,654.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,443.45	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	95,001.30	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,649.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	859.57	0.00	INJECTABLE DRUGS	57,299.47	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	96,335.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,358.78	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,668.77	9,442.92			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,523.48	1,900.34			
AUDIOLOGY	2,426.55	0.00			
CARDIOLOGY	14,141.04	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	443.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	637.95	0.00			
			TOTAL ANCILLARY	1,850,041.74	25,063.96
			TOTAL ACCOMODATIONS	551,505.00	76,200.00
			TOTAL CHARGES	2,401,546.74	101,263.96

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 15:25:02  
Page: 4

DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,724,332.82	ADJUSTMENTS	155,026.85
COVERED CHARGES	3,542,949.47	CONTRACTUAL ALLOW	2,715,091.83
NON-COVERD CHARGES	181,383.35	TOTAL MEDICAID LIAB	827,857.64
		LESS: COB	1,906.11
		LESS: COPAYMENT	2,895.16
		REIMBURSEMENT	823,056.37
		ALL OTHER	738,977.63
		FEE SCHEDULE-LAB	81,676.03
		INJECTABLE DRUGS	2,402.71
		TOTAL NUMBER OF CLAIMS	2,651

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER  
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,467.38	2,324.83	OTHER LAB	41,140.90	500.00
MED/SURG SUPPLY	360,443.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	114.11	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	191,819.11	425.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	377,168.32	12,528.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,681.60	180.95	FEE SCHEDULE LAB	629,014.72	124,298.14
EKG/ECG	64,162.24	1,583.71	MRI SERVICES	124,049.51	1,724.88
IV THERAPY	131,024.12	6,353.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	292,278.49	6,507.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	73,150.21	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,127.60	1,394.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	195,082.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	48,257.42	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	647,877.48	4,323.88	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,193.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,751.94	12,456.66
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	108.31	388.42	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,369.43
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	51,861.38	510.66			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,300.09	708.29			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,941.33	369.52			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,489.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,699.17	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	40,859.70	1,321.98			
			TOTAL ANCILLARY	3,542,949.47	181,383.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,542,949.47	181,383.35

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,521.81	ADJUSTMENTS	0.00
COVERED CHARGES	42,245.44	CONTRACTUAL ALLOW	19,543.97
NON-COVERD CHARGES	6,276.37	TOTAL MEDICAID LIAB	22,701.47
		LESS: COB	22,665.47
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

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

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER  
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	802.73	0.00	OTHER LAB	1,415.21	0.00
MED/SURG SUPPLY	4,246.63	38.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	978.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,562.47	885.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,672.87	0.00	FEE SCHEDULE LAB	9,591.20	3,457.00
EKG/ECG	538.51	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	322.93	141.69	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,013.81	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,262.82	834.08	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100.00	300.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,472.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,082.15	141.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	459.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	478.03
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	431.22	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,178.42	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	443.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	670.68	0.00			
			TOTAL ANCILLARY	42,245.44	6,276.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,245.44	6,276.37

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

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

Run Date: 09/24/2013  
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DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	284,004.20	ADJUSTMENTS	905.96
COVERED CHARGES	269,906.99	CONTRACTUAL ALLOW	252,006.19
NON-COVERD CHARGES	14,097.21	TOTAL MEDICAID LIAB	17,900.80
		LESS: COB	13.31
		LESS: COPAYMENT	723.06
		REIMBURSEMENT	17,164.43
		TOTAL NUMBER OF CLAIMS	320



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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,751.72	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,249.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,111.46	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,920.95	4,655.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,274.21	7,144.87
EKG/ECG	3,880.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,548.77	449.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	275.17	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	824.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	166,377.93	920.79	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,670.07	926.85
RADIOLOGY THERAPEUTIC	362.08	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	532.99	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	127.59	0.00			
			TOTAL ANCILLARY	269,906.99	14,097.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	269,906.99	14,097.21

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: 09/24/2013  
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DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,935.90	ADJUSTMENTS	0.00
COVERED CHARGES	4,758.84	CONTRACTUAL ALLOW	3,159.95
NON-COVERD CHARGES	2,177.06	TOTAL MEDICAID LIAB	1,598.89
		LESS: COB	1,592.89
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213.72	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	144.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	138.84	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	392.02	2,014.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	725.31	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	141.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,002.93	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	0.00	162.38
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	4,758.84	2,177.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,758.84	2,177.06

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

Run Date: 09/24/2013  
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Page: 12

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,441.73	ADJUSTMENTS	4,844.63
COVERED CHARGES	22,437.50	CONTRACTUAL ALLOW	17,589.87
NON-COVERD CHARGES	4.23	TOTAL MEDICAID LIAB	4,847.63
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,844.63
		TOTAL NUMBER OF CLAIMS	1

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28.37	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,212.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,412.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	2,707.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	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	76.67	4.23
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,437.50	4.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,437.50	4.23

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: 09/24/2013  
Run Time: 15:26:14  
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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:26:21  
 Page: 1

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,933,836.87	ADJUSTMENTS	55,207.38
COVERED CHARGES	1,904,096.12	CONTRACTUAL ALLOW	921,111.20
NON-COVERD CHARGES	29,740.75	TOTAL MEDICAID LIAB	982,984.92
		LESS: COB	7,366.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	975,618.68

TOTAL NUMBER OF ADMISSIONS 164

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	278		0	112,590.00		3,290.00
ROUTINE NURSERY	20		0	5,200.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	298		0	117,790.00		3,290.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	216		7	184,725.00		5,775.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	216		7	184,725.00		5,775.00
TOTAL ACCOMODATIONS	514		7	302,515.00		9,065.00

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	472,641.01	153.00	OTHER LAB	15,571.50	0.00
MED/SURG SUPPLY	147,058.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	300,526.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,328.25	0.00	OTHER THERAPEUTIC SVC	0.00	106.50
CT SCAN	113,178.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,388.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	28,694.50	0.00	MRI SERVICES	32,677.00	0.00
IV THERAPY	106.50	0.00	PROFESSIONAL FEES	0.00	700.50
OPERATING ROOM	66,310.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,679.75	3,190.25	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,057.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,720.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,620.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,091.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,952.50	0.00	INJECTABLE DRUGS	102,101.24	0.00
RADIOLOGY THERAPEUTIC	500.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	298.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,515.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,387.25	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,210.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	840.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,506.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	52,432.25	10,746.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,434.50	0.00			
AUDIOLOGY	255.00	0.00			
CARDIOLOGY	24,747.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	987.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,974.25	4,568.75			
			TOTAL ANCILLARY	1,601,581.12	20,675.75
			TOTAL ACCOMODATIONS	302,515.00	9,065.00
			TOTAL CHARGES	1,904,096.12	29,740.75



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

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

Run Date: 09/24/2013  
 Run Time: 15:26:28  
 Page: 3

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,625.97	ADJUSTMENTS	0.00
COVERED CHARGES	4,610.97	CONTRACTUAL ALLOW	880.15
NON-COVERD CHARGES	15.00	TOTAL MEDICAID LIAB	3,730.82
		LESS: COB	3,730.82
		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	1		0	405.00		15.00
ROUTINE NURSERY	0		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	405.00		15.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	405.00		15.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER  
 200 PERRY HOUSE RD  
 FITZGERALD,GA 31750-8857

PROVIDER NUMBER  
 000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	734.62	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	746.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	372.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	435.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	374.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	581.88	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	4,205.97	0.00
			TOTAL ACCOMODATIONS	405.00	15.00
			TOTAL CHARGES	4,610.97	15.00

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: 09/24/2013  
Run Time: 15:26:28  
Page: 5

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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,196,654.60	ADJUSTMENTS	62,756.98
COVERED CHARGES	1,857,578.81	CONTRACTUAL ALLOW	1,324,396.21
NON-COVERD CHARGES	339,075.79	TOTAL MEDICAID LIAB	533,182.60
		LESS: COB	1,502.00
		LESS: COPAYMENT	3,387.00
		REIMBURSEMENT	528,293.60
		ALL OTHER	439,774.19
		FEE SCHEDULE-LAB	56,204.65
		INJECTABLE DRUGS	32,314.76

TOTAL NUMBER OF CLAIMS 2,094

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

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

Run Date: 09/24/2013  
 Run Time: 15:26:28  
 Page: 6

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,017.94	37,422.54	OTHER LAB	21,715.00	0.00
MED/SURG SUPPLY	127,785.23	915.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	131.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,938.75	3,397.00	OTHER THERAPEUTIC SVC	0.00	6,922.50
CT SCAN	173,598.25	47,886.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,726.50	11,759.50	FEE SCHEDULE LAB	353,049.57	70,130.65
EKG/ECG	24,362.75	143.50	MRI SERVICES	85,192.75	0.00
IV THERAPY	1,107.25	0.00	PROFESSIONAL FEES	0.00	700.50
OPERATING ROOM	105,313.25	54,421.50	DURABLE MED. EQUIP.	0.00	40.00
LABOR/DELIVERY ROOM	11,406.75	484.25	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,803.00	6,208.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,425.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	154,775.50	2,937.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,763.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	189,430.94	62,891.77
RADIOLOGY THERAPEUTIC	29,430.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,881.50	3,740.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,386.50	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	49,133.13	1,476.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,156.75	5,917.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	57,258.75	3,529.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,356.25	9,393.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	39,652.75	6,894.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,953.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	53,813.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,144.50	1,734.75			
			TOTAL ANCILLARY	1,857,578.81	339,075.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,857,578.81	339,075.79

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

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

Run Date: 09/24/2013  
Run Time: 15:27:17  
Page: 7

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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,935.31	ADJUSTMENTS	0.00
COVERED CHARGES	16,707.56	CONTRACTUAL ALLOW	8,210.63
NON-COVERD CHARGES	3,227.75	TOTAL MEDICAID LIAB	8,496.93
		LESS: COB	8,461.88
		LESS: COPAYMENT	35.05
		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

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,019.00	643.00	OTHER LAB	1,322.75	0.00
MED/SURG SUPPLY	1,347.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	408.75	0.00	OTHER THERAPEUTIC SVC	0.00	53.25
CT SCAN	0.00	955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,091.25	599.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	398.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	279.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,833.25	255.25	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	20.00	191.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	508.50	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	2,574.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,393.75	530.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	511.00	0.00			
			TOTAL ANCILLARY	16,707.56	3,227.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,707.56	3,227.75

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: 09/24/2013  
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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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	153,296.90	ADJUSTMENTS	1,829.96
COVERED CHARGES	137,005.40	CONTRACTUAL ALLOW	118,100.37
NON-COVERD CHARGES	16,291.50	TOTAL MEDICAID LIAB	18,905.03
		LESS: COB	0.00
		LESS: COPAYMENT	639.02
		REIMBURSEMENT	18,266.01
		TOTAL NUMBER OF CLAIMS	338

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,018.50	4,244.00	OTHER LAB	955.00	0.00
MED/SURG SUPPLY	4,473.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,802.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,488.50	4,132.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,515.75	5,194.25
EKG/ECG	2,439.50	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	1,792.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,992.04	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,320.00	876.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,035.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,927.25	53.25			
			TOTAL ANCILLARY	137,005.40	16,291.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	137,005.40	16,291.50



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

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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,606.10	ADJUSTMENTS	0.00
COVERED CHARGES	3,020.85	CONTRACTUAL ALLOW	2,536.41
NON-COVERD CHARGES	2,585.25	TOTAL MEDICAID LIAB	484.44
		LESS: COB	472.44
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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

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

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	462.50	53.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	145.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	541.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,222.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	762.75	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	64.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,045.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.00	161.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53.25	53.25			
			TOTAL ANCILLARY	3,020.85	2,585.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,020.85	2,585.25

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

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

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

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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	329,294.82	ADJUSTMENTS	33,171.14
COVERED CHARGES	319,965.07	CONTRACTUAL ALLOW	273,677.07
NON-COVERD CHARGES	9,329.75	TOTAL MEDICAID LIAB	46,288.00
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	46,150.00
		TOTAL NUMBER OF CLAIMS	10

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,087.06	490.25	OTHER LAB	583.50	0.00
MED/SURG SUPPLY	4,496.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	371.50	0.00	OTHER THERAPEUTIC SVC	0.00	4,686.00
CT SCAN	3,601.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,819.00	1,355.00
EKG/ECG	0.00	0.00	MRI SERVICES	2,122.00	0.00
IV THERAPY	1,176.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	172.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	257,091.94	160.00
RADIOLOGY THERAPEUTIC	16,440.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,251.25	648.50	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	265.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,433.75	1,990.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53.25	0.00			
			TOTAL ANCILLARY	319,965.07	9,329.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	319,965.07	9,329.75

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

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

Run Date: 09/24/2013  
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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	08/01/11	THROUGH	07/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:27:34  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,765,453.40	ADJUSTMENTS	1,292,987.31
COVERED CHARGES	21,390,639.49	CONTRACTUAL ALLOW	15,169,998.42
NON-COVERD CHARGES	374,813.91	TOTAL MEDICAID LIAB	6,220,641.07
		LESS: COB	57,651.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,162,989.69

TOTAL NUMBER OF ADMISSIONS 785

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,290	16	1,298,934.00	31,716.00
ROUTINE NURSERY	217	0	78,390.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,507	16	1,377,324.00	31,716.00
SPECIAL CARE SERVICES				
CCU	1,441	7	2,036,484.00	10,094.00
ICU	276	0	636,001.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,717	7	2,672,485.00	10,094.00
TOTAL ACCOMODATIONS	3,224	23	4,049,809.00	41,810.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,970,167.13	22,231.50	OTHER LAB	175,550.00	0.00
MED/SURG SUPPLY	677,764.01	6,125.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,173,736.82	5,400.00	EDUCATION & TRAINING	6,026.00	0.00
RADIOLOGY-DIAGNOSTIC	533,764.00	2,376.00	OTHER THERAPEUTIC SVC	0.00	365.00
CT SCAN	1,540,345.00	7,775.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	61,478.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	157,583.00	269.00	MRI SERVICES	479,704.00	0.00
IV THERAPY	414,485.00	50,891.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	998,247.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	624,693.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,472,937.00	7,037.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	270,055.00	424.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	996,023.00	1,197.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	124,638.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	121,592.06	818.00	INJECTABLE DRUGS	1,016.00	0.00
RADIOLOGY THERAPEUTIC	2,559.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,563.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,621.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	485,784.00	88,749.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,539.00	801.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	336.00	0.00	IMPL DEV CHARGE PATIENTS	167,203.00	1,560.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	24,741.00
OTHER IMAGING SERVICE	137,133.00	881.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	128,431.00	71,549.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	483,325.00	27,899.00			
AUDIOLOGY	37,492.00	0.00			
CARDIOLOGY	959,821.00	2,499.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	68,385.00	995.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,834.47	8,421.41			
			TOTAL ANCILLARY	17,340,830.49	333,003.91
			TOTAL ACCOMODATIONS	4,049,809.00	41,810.00
			TOTAL CHARGES	21,390,639.49	374,813.91

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: 09/24/2013  
Run Time: 15:27:34  
Page: 3

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

PROVIDER NUMBER  
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012234054612	05/12/12 - 05/24/12	08/27/12	0.00	6,533.00	0.00	0.00	0.00
615	2012296032347	12/29/11 - 01/01/12	10/29/12	0.00	6,533.00	0.00	0.00	0.00
615	2212297002131	10/25/11 - 11/19/11	10/29/12	0.00	5,781.00	0.00	0.00	0.00
615	2012299077346	06/06/12 - 06/12/12	10/29/12	0.00	2,947.00	0.00	0.00	0.00
615	2013266064615	06/22/12 - 06/26/12	01/01/00	0.00	2,947.00	0.00	0.00	0.00
TOTAL				0.00	24,741.00	0.00	0.00	0.00



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	80,260.25	ADJUSTMENTS	0.00
COVERED CHARGES	71,054.25	CONTRACTUAL ALLOW	20,418.35
NON-COVERD CHARGES	9,206.00	TOTAL MEDICAID LIAB	50,635.90
		LESS: COB	50,635.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	5,070.00		30.00
ROUTINE NURSERY	0		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	5,070.00		30.00
SPECIAL CARE SERVICES						
CCU	5		0	7,010.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	7,010.00		0.00
TOTAL ACCOMODATIONS	10		0	12,080.00		30.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,250.25	2,761.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	221.00	3,386.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,833.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	351.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,252.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	393.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	269.00	269.00	MRI SERVICES	0.00	0.00
IV THERAPY	776.00	921.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,826.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,454.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,919.00	181.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,469.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,371.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,156.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	189.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	9,342.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,557.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,004.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	58,974.25	9,176.00
			TOTAL ACCOMODATIONS	12,080.00	30.00
			TOTAL CHARGES	71,054.25	9,206.00

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,510,971.44	ADJUSTMENTS	302,847.25
COVERED CHARGES	11,753,401.93	CONTRACTUAL ALLOW	9,417,374.20
NON-COVERD CHARGES	757,569.51	TOTAL MEDICAID LIAB	2,336,027.73
		LESS: COB	10,408.22
		LESS: COPAYMENT	3,535.57
		REIMBURSEMENT	2,322,083.94
		ALL OTHER	2,135,624.24
		FEE SCHEDULE-LAB	137,348.18
		INJECTABLE DRUGS	49,111.52

TOTAL NUMBER OF CLAIMS 5,268

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

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

Run Date: 09/24/2013  
 Run Time: 15:28:13  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	472,976.75	1,447.75	OTHER LAB	72,577.00	2,709.00
MED/SURG SUPPLY	140,591.00	184.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	160.76	EDUCATION & TRAINING	1,128.00	987.00
RADIOLOGY-DIAGNOSTIC	735,281.00	3,934.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,875,540.00	132,416.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,725.00	7,709.00	FEE SCHEDULE LAB	1,933,187.66	220,576.00
EKG/ECG	148,100.00	2,152.00	MRI SERVICES	307,400.00	31,834.00
IV THERAPY	420,493.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	551,886.00	108,310.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	86,366.00	0.00	REHAB THERAPY	1,950.00	0.00
RESPIRATORY SERVICES	100,436.00	31,447.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	216,476.00	8,056.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,085,625.00	11,413.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	142,110.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	204,798.00	123,968.00
RADIOLOGY THERAPEUTIC	37,240.00	5,958.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,708.00	320.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	18,684.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,977.00	3,240.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,162.00	900.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	336,393.00	15,998.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,501.00	1,395.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	312,790.00	8,956.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	158,561.00	13,811.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	125,117.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	191,306.52	1,004.00			
			TOTAL ANCILLARY	11,753,401.93	757,569.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,753,401.93	757,569.51

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	330,376.09	ADJUSTMENTS	0.00
COVERED CHARGES	284,432.34	CONTRACTUAL ALLOW	80,016.18
NON-COVERD CHARGES	45,943.75	TOTAL MEDICAID LIAB	204,416.16
		LESS: COB	204,330.68
		LESS: COPAYMENT	85.48
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 156

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

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

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,130.25	0.00	OTHER LAB	1,659.00	0.00
MED/SURG SUPPLY	4,994.00	124.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,500.00	351.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,520.00	18,874.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	46,808.09	6,877.50
EKG/ECG	6,163.00	269.00	MRI SERVICES	3,527.00	0.00
IV THERAPY	8,847.00	66.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,938.00	8,610.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,031.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,400.00	2,144.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,469.00	5,879.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,223.00	1,827.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,201.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	850.25
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	349.00	72.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	761.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,441.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,340.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,848.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,570.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,713.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	284,432.34	45,943.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	284,432.34	45,943.75

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: 09/24/2013  
Run Time: 15:29:39  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,173,660.00	ADJUSTMENTS	1,642.19
COVERED CHARGES	1,137,653.50	CONTRACTUAL ALLOW	1,081,937.26
NON-COVERD CHARGES	36,006.50	TOTAL MEDICAID LIAB	55,716.24
		LESS: COB	0.00
		LESS: COPAYMENT	1,689.01
		REIMBURSEMENT	54,027.23
		TOTAL NUMBER OF CLAIMS	996

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,989.75	8.75	OTHER LAB	6,686.00	2,709.00
MED/SURG SUPPLY	5,419.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,682.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,884.00	6,895.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	236,744.00	16,492.00
EKG/ECG	13,181.00	0.00	MRI SERVICES	9,418.00	0.00
IV THERAPY	39,849.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,959.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,551.00	2,323.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	424.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	629,533.00	5,072.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	865.75	196.75
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	72.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,545.00	1,814.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,848.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,499.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,137,653.50	36,006.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,137,653.50	36,006.50



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

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

Run Date: 09/24/2013  
 Run Time: 15:29:51  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,418.75	ADJUSTMENTS	0.00
COVERED CHARGES	31,331.50	CONTRACTUAL ALLOW	10,492.09
NON-COVERD CHARGES	1,087.25	TOTAL MEDICAID LIAB	20,839.41
		LESS: COB	20,806.41
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

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

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

Run Date: 09/24/2013  
 Run Time: 15:29:51  
 Page: 13

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	913.50	312.25	OTHER LAB	903.00	0.00
MED/SURG SUPPLY	67.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,481.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,480.00	179.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,072.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	183.00	509.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,963.00	87.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,331.50	1,087.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,331.50	1,087.25

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	940,932.20	ADJUSTMENTS	66,822.76
COVERED CHARGES	884,095.95	CONTRACTUAL ALLOW	741,058.94
NON-COVERD CHARGES	56,836.25	TOTAL MEDICAID LIAB	143,037.01
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	142,914.01
		TOTAL NUMBER OF CLAIMS	28

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,764.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,408.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,851.00	1,083.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,726.00	4,651.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,393.00	1,092.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,293.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,911.00	5,766.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	181.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,236.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,798.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,321.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	664,792.75	41,843.25
RADIOLOGY THERAPEUTIC	26,111.00	2,052.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,899.00	349.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,760.00	0.00
LITHOTRIPSY	26,328.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,126.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,440.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,455.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,032.70	0.00			
			TOTAL ANCILLARY	884,095.95	56,836.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	884,095.95	56,836.25

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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:30:06  
 Page: 1

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY, GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	158,797.00	ADJUSTMENTS	10,250.57
COVERED CHARGES	157,231.00	CONTRACTUAL ALLOW	66,926.04
NON-COVERD CHARGES	1,566.00	TOTAL MEDICAID LIAB	90,304.96
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	90,304.96

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	62		0	33,480.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	62		0	33,480.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	62		0	33,480.00		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: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY, GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,860.00	0.00	OTHER LAB	689.00	0.00
MED/SURG SUPPLY	3,806.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,397.00	0.00	EDUCATION & TRAINING	67.00	0.00
RADIOLOGY-DIAGNOSTIC	3,162.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,089.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	562.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,300.00	0.00	MRI SERVICES	3,132.00	0.00
IV THERAPY	1,617.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,036.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,300.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,012.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	582.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	555.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,566.00
OTHER IMAGING SERVICE	880.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,705.00	0.00			
			TOTAL ANCILLARY	123,751.00	1,566.00
			TOTAL ACCOMODATIONS	33,480.00	0.00
			TOTAL CHARGES	157,231.00	1,566.00

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: 09/24/2013  
Run Time: 15:30:06  
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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY, GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5912333001961	08/27/12 - 08/30/12	12/03/12	0.00	1,566.00	0.00	0.00	0.00
TOTAL				0.00	1,566.00	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: 09/24/2013  
Run Time: 15:30:07  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY, GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 15:30:08  
Page: 5

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	933,699.00	ADJUSTMENTS	9,524.60
COVERED CHARGES	847,464.00	CONTRACTUAL ALLOW	566,651.83
NON-COVERD CHARGES	86,235.00	TOTAL MEDICAID LIAB	280,812.17
		LESS: COB	388.05
		LESS: COPAYMENT	951.00
		REIMBURSEMENT	279,473.12
		ALL OTHER	256,338.46
		FEE SCHEDULE-LAB	22,728.01
		INJECTABLE DRUGS	406.65

TOTAL NUMBER OF CLAIMS 927

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

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

Run Date: 09/24/2013  
 Run Time: 15:30:08  
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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY, GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,436.00	0.00	OTHER LAB	2,172.00	0.00
MED/SURG SUPPLY	8,129.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,850.00	895.00	OTHER THERAPEUTIC SVC	0.00	419.00
CT SCAN	105,887.00	19,855.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,317.00	1,059.00	FEE SCHEDULE LAB	266,462.00	50,466.00
EKG/ECG	9,687.00	0.00	MRI SERVICES	4,698.00	0.00
IV THERAPY	5,744.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,756.00	8,933.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	284,721.00	3,672.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,200.00	936.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	880.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	390.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,640.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,495.00	0.00			
			TOTAL ANCILLARY	847,464.00	86,235.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	847,464.00	86,235.00

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: 09/24/2013  
Run Time: 15:30:22  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,301.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,400.00	CONTRACTUAL ALLOW	843.00
NON-COVERD CHARGES	2,901.00	TOTAL MEDICAID LIAB	3,557.00
		LESS: COB	3,557.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY, GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	185.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	98.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,155.00	2,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	481.00	38.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	363.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,481.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,400.00	2,901.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,400.00	2,901.00

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: 09/24/2013  
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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	151,754.53	ADJUSTMENTS	191.00
COVERED CHARGES	146,394.53	CONTRACTUAL ALLOW	137,091.00
NON-COVERD CHARGES	5,360.00	TOTAL MEDICAID LIAB	9,303.53
		LESS: COB	0.00
		LESS: COPAYMENT	303.00
		REIMBURSEMENT	9,000.53
		TOTAL NUMBER OF CLAIMS	187

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY, GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,217.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	248.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,639.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,903.00	1,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,903.00	2,684.00
EKG/ECG	1,170.00	0.00	MRI SERVICES	1,566.00	0.00
IV THERAPY	1,575.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,968.53	1,315.00	SPECIAL SERVICES	0.00	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	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,890.00	0.00			
			TOTAL ANCILLARY	146,394.53	5,360.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	146,394.53	5,360.00

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: 09/24/2013  
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PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,901.16	ADJUSTMENTS	0.00
COVERED CHARGES	75,385.16	CONTRACTUAL ALLOW	71,026.95
NON-COVERD CHARGES	516.00	TOTAL MEDICAID LIAB	4,358.21
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	4,343.21
		TOTAL NUMBER OF CLAIMS	1

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

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY,GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,697.16	0.00	OTHER LAB	0.00	440.00
MED/SURG SUPPLY	15.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	716.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	957.00	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	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
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	75,385.16	516.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	75,385.16	516.00

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,865.30	ADJUSTMENTS	5,984.13
COVERED CHARGES	52,883.30	CONTRACTUAL ALLOW	23,049.40
NON-COVERD CHARGES	10,982.00	TOTAL MEDICAID LIAB	29,833.90
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,833.90

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	6,750.00		10,982.00
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	9		0	6,750.00		10,982.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	6,750.00		10,982.00

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

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

Run Date: 09/24/2013  
 Run Time: 15:31:32  
 Page: 2

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,436.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,667.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,049.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,460.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,778.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,688.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	77.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,002.00	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	5,450.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	206.00	0.00	INJECTABLE DRUGS	427.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	893.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	46,133.30	0.00
			TOTAL ACCOMODATIONS	6,750.00	10,982.00
			TOTAL CHARGES	52,883.30	10,982.00

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

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

Run Date: 09/24/2013  
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Page: 3

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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 15:31:36  
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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,398,577.86	ADJUSTMENTS	20,461.25
COVERED CHARGES	1,225,986.46	CONTRACTUAL ALLOW	811,814.13
NON-COVERD CHARGES	172,591.40	TOTAL MEDICAID LIAB	414,172.33
		LESS: COB	2,977.21
		LESS: COPAYMENT	1,533.00
		REIMBURSEMENT	409,662.12
		ALL OTHER	382,941.69
		FEE SCHEDULE-LAB	24,403.49
		INJECTABLE DRUGS	2,316.94
		TOTAL NUMBER OF CLAIMS	1,200

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,688.00	43.00	OTHER LAB	21,580.00	4,075.00
MED/SURG SUPPLY	56,932.96	690.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97,693.00	2,973.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,184.00	92,486.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,666.00	0.00	FEE SCHEDULE LAB	250,400.00	45,929.40
EKG/ECG	19,015.50	0.00	MRI SERVICES	44,105.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	68.00
OPERATING ROOM	28,274.00	6,498.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,308.00	622.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,469.00	2,562.00	AMBULANCE	0.00	0.00
GI SERVICES	33,270.00	5,899.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	446,478.00	4,126.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,705.00	648.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,806.00	55.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,882.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,706.00	5,353.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,630.00	564.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,194.00	0.00			
			TOTAL ANCILLARY	1,225,986.46	172,591.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,225,986.46	172,591.40



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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,541.50	ADJUSTMENTS	0.00
COVERED CHARGES	14,905.50	CONTRACTUAL ALLOW	6,991.35
NON-COVERD CHARGES	1,636.00	TOTAL MEDICAID LIAB	7,914.15
		LESS: COB	7,905.15
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	534.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,446.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,653.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,412.00	287.00
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	1,349.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,190.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,358.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,905.50	1,636.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,905.50	1,636.00

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: 09/24/2013  
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Page: 8

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	157,411.00	ADJUSTMENTS	344.00
COVERED CHARGES	142,324.00	CONTRACTUAL ALLOW	135,574.00
NON-COVERD CHARGES	15,087.00	TOTAL MEDICAID LIAB	6,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	6,573.00
		TOTAL NUMBER OF CLAIMS	135

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,695.00	48.00	OTHER LAB	657.00	0.00
MED/SURG SUPPLY	2,001.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,258.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,024.00	12,662.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,454.00	1,731.00
EKG/ECG	768.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	107,378.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	707.00	28.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,812.00	618.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	142,324.00	15,087.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	142,324.00	15,087.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,322.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,322.00	CONTRACTUAL ALLOW	839.37
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	482.63
		LESS: COB	482.63
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,300.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,322.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,322.00	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

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,934.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,904.00	CONTRACTUAL ALLOW	19,399.37
NON-COVERD CHARGES	30.00	TOTAL MEDICAID LIAB	4,504.63
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,504.63

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,243.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	73.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	242.00	30.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,340.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,904.00	30.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,904.00	30.00



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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	764,325.58	ADJUSTMENTS	5,909.65
COVERED CHARGES	739,197.62	CONTRACTUAL ALLOW	335,487.30
NON-COVERD CHARGES	25,127.96	TOTAL MEDICAID LIAB	403,710.32
		LESS: COB	1,071.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	402,638.57

TOTAL NUMBER OF ADMISSIONS 62

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	199		0	103,880.00		21,433.96
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	199		0	103,880.00		21,433.96
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	20		0	24,100.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		4	0.00		1,156.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	20		4	24,100.00		1,156.00
TOTAL ACCOMODATIONS	219		4	127,980.00		22,589.96

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,327.42	0.00	OTHER LAB	4,029.00	0.00
MED/SURG SUPPLY	44,255.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	129,101.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,223.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,944.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,806.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,179.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,602.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	114,750.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,179.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,330.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,798.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,669.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	595.50	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	4,139.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,440.00	1,668.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,892.00	870.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,067.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	551.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	339.00	0.00			
			TOTAL ANCILLARY	611,217.62	2,538.00
			TOTAL ACCOMODATIONS	127,980.00	22,589.96
			TOTAL CHARGES	739,197.62	25,127.96

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,994.12	ADJUSTMENTS	0.00
COVERED CHARGES	4,643.12	CONTRACTUAL ALLOW	2,003.09
NON-COVERD CHARGES	351.00	TOTAL MEDICAID LIAB	2,640.03
		LESS: COB	2,640.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	1,524.00		351.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	1,524.00		351.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	1,524.00		351.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,683.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,265.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	171.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	3,119.12	0.00
			TOTAL ACCOMODATIONS	1,524.00	351.00
			TOTAL CHARGES	4,643.12	351.00

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: 09/24/2013  
Run Time: 15:32:25  
Page: 5

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,376,183.69	ADJUSTMENTS	43,314.14
COVERED CHARGES	1,273,676.86	CONTRACTUAL ALLOW	972,037.69
NON-COVERD CHARGES	102,506.83	TOTAL MEDICAID LIAB	301,639.17
		LESS: COB	0.00
		LESS: COPAYMENT	1,326.00
		REIMBURSEMENT	300,313.17
		ALL OTHER	271,674.62
		FEE SCHEDULE-LAB	28,512.92
		INJECTABLE DRUGS	125.63
		TOTAL NUMBER OF CLAIMS	1,093

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

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

Run Date: 09/24/2013  
 Run Time: 15:32:25  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,930.28	17,080.77	OTHER LAB	13,269.00	0.00
MED/SURG SUPPLY	14,333.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	242.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	115,253.00	1,372.00	OTHER THERAPEUTIC SVC	0.00	124.00
CT SCAN	175,275.00	36,497.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,200.00	2,070.00	FEE SCHEDULE LAB	288,710.00	31,870.00
EKG/ECG	18,908.00	137.00	MRI SERVICES	46,293.00	0.00
IV THERAPY	60,511.48	1,135.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,720.00	3,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,459.50	264.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,743.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	267,600.00	1,262.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,712.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,796.70	2,655.06
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	37,471.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,245.00	1,668.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,828.00	2,456.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,721.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,301.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,396.00	174.00			
			TOTAL ANCILLARY	1,273,676.86	102,506.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,273,676.86	102,506.83

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

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,623.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,940.50	CONTRACTUAL ALLOW	833.02
NON-COVERD CHARGES	1,682.50	TOTAL MEDICAID LIAB	4,107.48
		LESS: COB	4,104.48
		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

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

PROVIDER NUMBER  
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139.50	144.50	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	449.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,435.00	38.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	217.00	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	81.00	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	1,805.00	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	24.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	222.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,940.50	1,682.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,940.50	1,682.50

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: 09/24/2013  
Run Time: 15:32:48  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,462.52	ADJUSTMENTS	270.70
COVERED CHARGES	52,461.02	CONTRACTUAL ALLOW	47,873.94
NON-COVERD CHARGES	1,001.50	TOTAL MEDICAID LIAB	4,587.08
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	4,431.08
		TOTAL NUMBER OF CLAIMS	82

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	665.02	741.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,408.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,151.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,349.00	260.00
EKG/ECG	137.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,540.50	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	324.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,476.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,250.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	52,461.02	1,001.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,461.02	1,001.50

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: 09/24/2013  
Run Time: 15:32:50  
Page: 11

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,371.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,352.50	CONTRACTUAL ALLOW	445.58
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	906.92
		LESS: COB	906.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125.50	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	392.00	19.00
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	575.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,352.50	19.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,352.50	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

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

EMANUEL MEDICAL CENTER  
 117 KITE RD  
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER 000000701A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,128,863.50	ADJUSTMENTS	17,172.08
COVERED CHARGES	2,084,883.50	CONTRACTUAL ALLOW	1,098,678.84
NON-COVERD CHARGES	43,980.00	TOTAL MEDICAID LIAB	986,204.66
		LESS: COB	9,595.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	976,608.67

TOTAL NUMBER OF ADMISSIONS 191

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	495		0	227,205.00		30,982.00
ROUTINE NURSERY	47		0	21,573.00		5,959.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	542		0	248,778.00		36,941.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	93		0	102,486.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	93		0	102,486.00		0.00
TOTAL ACCOMODATIONS	635		0	351,264.00		36,941.00



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	648,801.50	0.00	OTHER LAB	9,336.00	0.00
MED/SURG SUPPLY	84,591.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	391,249.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,485.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,509.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,286.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	21,024.00	0.00	MRI SERVICES	6,708.00	0.00
IV THERAPY	27,421.00	0.00	PROFESSIONAL FEES	0.00	4,436.00
OPERATING ROOM	48,909.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,927.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	162,534.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,409.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,934.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,569.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,252.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,436.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	610.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,166.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,630.00	1,167.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	924.00	0.00			
AUDIOLOGY	5,442.00	0.00			
CARDIOLOGY	23,876.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,027.00	0.00			
			TOTAL ANCILLARY	1,733,619.50	7,039.00
			TOTAL ACCOMODATIONS	351,264.00	36,941.00
			TOTAL CHARGES	2,084,883.50	43,980.00

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

EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,937,164.19	ADJUSTMENTS	22,132.07
COVERED CHARGES	2,664,798.49	CONTRACTUAL ALLOW	2,133,101.09
NON-COVERD CHARGES	272,365.70	TOTAL MEDICAID LIAB	531,697.40
		LESS: COB	100.80
		LESS: COPAYMENT	2,310.00
		REIMBURSEMENT	529,286.60
		ALL OTHER	468,624.23
		FEE SCHEDULE-LAB	60,662.37
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,254

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233,708.00	742.00	OTHER LAB	10,441.00	2,870.00
MED/SURG SUPPLY	109,207.99	1,198.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	257.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	157,388.00	11,749.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	241,612.00	21,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	726,964.50	183,711.70
EKG/ECG	36,456.00	240.00	MRI SERVICES	82,205.00	7,832.00
IV THERAPY	71,677.00	1,102.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,300.00	13,068.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,411.00	546.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,760.00	100.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,079.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	481,183.00	9,616.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,929.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	219.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,222.00	724.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44.00	2,441.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	100.00
OTHER IMAGING SERVICE	136,463.00	4,087.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,842.00	1,975.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,690.00	0.00			
AUDIOLOGY	0.00	279.00			
CARDIOLOGY	33,115.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,254.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	106,847.00	7,779.00			
			TOTAL ANCILLARY	2,664,798.49	272,365.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,664,798.49	272,365.70

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
791	5912290000258	06/13/12 - 06/13/12	10/22/12	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	100.00	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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,166.00	ADJUSTMENTS	0.00
COVERED CHARGES	15,018.00	CONTRACTUAL ALLOW	9,617.29
NON-COVERD CHARGES	2,148.00	TOTAL MEDICAID LIAB	5,400.71
		LESS: COB	5,398.29
		LESS: COPAYMENT	2.42
		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

EMANUEL MEDICAL CENTER  
 117 KITE RD  
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,639.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,609.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	491.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,121.00	1,235.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,976.00	721.00
EKG/ECG	192.00	192.00	MRI SERVICES	0.00	0.00
IV THERAPY	392.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,035.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	455.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,205.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	445.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	458.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,018.00	2,148.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,018.00	2,148.00

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: 09/24/2013  
Run Time: 15:34:01  
Page: 9

EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	276,974.00	ADJUSTMENTS	161.82
COVERED CHARGES	266,298.00	CONTRACTUAL ALLOW	246,998.70
NON-COVERD CHARGES	10,676.00	TOTAL MEDICAID LIAB	19,299.30
		LESS: COB	0.00
		LESS: COPAYMENT	531.00
		REIMBURSEMENT	18,768.30
		TOTAL NUMBER OF CLAIMS	345



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,712.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,467.00	89.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,002.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,981.00	1,550.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,876.00	7,613.00
EKG/ECG	1,680.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,398.00	142.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,222.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	127,948.00	80.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	100.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,947.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	327.00	718.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	279.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,638.00	205.00			
			TOTAL ANCILLARY	266,298.00	10,676.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	266,298.00	10,676.00

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: 09/24/2013  
Run Time: 15:34:08  
Page: 11

EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,129.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,129.00	CONTRACTUAL ALLOW	222.80
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	906.20
		LESS: COB	903.20
		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: 09/24/2013  
 Run Time: 15:34:08  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.00	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	321.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	204.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	71.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	453.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,129.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,129.00	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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 15:34:10  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:34:17  
 Page: 1

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,179,256.31	ADJUSTMENTS	11,313,322.18
COVERED CHARGES	111,642,575.14	CONTRACTUAL ALLOW	73,819,039.51
NON-COVERD CHARGES	5,536,681.17	TOTAL MEDICAID LIAB	37,823,535.63
		LESS: COB	153,635.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	37,669,900.17

TOTAL NUMBER OF ADMISSIONS 1,916

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,635		19	9,470,532.40		652,655.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,165.00
TOTAL ROUTINE	8,635		19	9,470,532.40		653,820.00
SPECIAL CARE SERVICES						
CCU	571		0	2,290,145.00		0.00
ICU	6,365		0	17,683,985.50		64,515.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	634		0	1,173,755.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		1,941	0.00		3,062,433.10
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7,570		1,941	21,147,885.50		3,126,948.10
TOTAL ACCOMODATIONS	16,205		1,960	30,618,417.90		3,780,768.10

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,377,627.04	60,032.21	OTHER LAB	774,375.00	3,696.00
MED/SURG SUPPLY	6,986,528.52	262,465.27	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,243,978.70	197,279.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,032,274.70	14,743.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,248,757.40	38,911.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,611,697.00	13,183.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	273,132.00	832.00	MRI SERVICES	3,218,381.90	11,394.00
IV THERAPY	11,775.00	1,317.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,280,868.00	64,280.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,023,512.54	98,809.46	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,963,288.00	15,060.00	AMBULANCE	0.00	0.00
GI SERVICES	363,246.00	1,461.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,082,850.00	19,190.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	586,288.00	11,583.00	DRUG-SPECIFIC/HOME IV	0.00	72,138.28
LABORATORY PATHOLOGIC	994,252.00	2,471.00	INJECTABLE DRUGS	12,475,775.31	223,651.85
RADIOLOGY THERAPEUTIC	104,909.75	7,264.00	HOME HEALTH SERVICES	0.00	783.00
OCCUPATIONAL THERAPY	1,491,674.00	12,661.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	615,019.00	3,665.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	842,907.00	72,667.00	PATIENT CONVENIENCE	0.00	282.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	25,969.00	0.00	IMPL DEV CHARGE PATIENTS	2,175,305.73	1,774.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	148,316.00
OTHER IMAGING SERVICE	247,090.00	152,997.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,686,204.40	18,511.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,220.00	66,926.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,946,607.00	3,292.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,251,560.00	0.00			
ORGAN ACQUISITION	923,648.25	153,698.00			
TREATMENT/OBSERV. RM	34,400.00	580.00			
			TOTAL ANCILLARY	81,024,157.24	1,755,913.07
			TOTAL ACCOMODATIONS	30,618,417.90	3,780,768.10
			TOTAL CHARGES	111,642,575.14	5,536,681.17

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012187056984	06/18/12 - 06/29/12	07/09/12	0.00	5,697.00	0.00	0.00	0.00
614	2012191010430	06/11/12 - 06/16/12	07/16/12	0.00	5,697.00	0.00	0.00	0.00
614	2012191010506	12/14/11 - 12/20/11	07/16/12	0.00	5,697.00	0.00	0.00	0.00
614	2012201020148	03/05/12 - 03/22/12	07/23/12	0.00	5,697.00	0.00	0.00	0.00
614	2212219004069	06/11/12 - 07/16/12	08/13/12	0.00	5,697.00	0.00	0.00	0.00
614	2012222003476	03/20/12 - 03/27/12	08/13/12	0.00	5,697.00	0.00	0.00	0.00
614	2012227011945	07/26/12 - 08/08/12	08/27/12	0.00	5,697.00	0.00	0.00	0.00
614	2012229033273	06/05/12 - 06/13/12	08/20/12	0.00	5,697.00	0.00	0.00	0.00
614	2012233011242	02/04/12 - 02/17/12	08/27/12	0.00	11,394.00	0.00	0.00	0.00
614	2012243015552	08/21/12 - 08/24/12	09/03/12	0.00	5,697.00	0.00	0.00	0.00
614	2312243000103	04/20/12 - 04/27/12	10/29/12	0.00	194.00	0.00	0.00	0.00
614	2012258008221	07/09/12 - 07/13/12	09/17/12	0.00	5,697.00	0.00	0.00	0.00
614	2012262032070	08/25/12 - 09/11/12	09/24/12	0.00	5,697.00	0.00	0.00	0.00
614	2212277013968	04/26/12 - 05/05/12	10/08/12	0.00	5,697.00	0.00	0.00	0.00
614	2012284016610	03/18/12 - 03/22/12	10/15/12	0.00	5,697.00	0.00	0.00	0.00
614	5212284000068	05/26/12 - 06/22/12	10/15/12	0.00	5,697.00	0.00	0.00	0.00
614	2012292043489	07/15/12 - 08/01/12	10/22/12	0.00	5,697.00	0.00	0.00	0.00
614	5212313000125	07/27/12 - 08/14/12	11/12/12	0.00	5,697.00	0.00	0.00	0.00
24	9113023002579	05/04/12 - 05/04/12	02/18/13	0.00	0.00	0.00	7,645.23	0.00
614	5213046000073	08/01/12 - 08/24/12	02/25/13	0.00	5,697.00	0.00	0.00	0.00
614	2013060033964	06/01/12 - 06/11/12	03/04/13	0.00	5,697.00	0.00	0.00	0.00
614	5213065000006	07/28/12 - 08/28/12	03/11/13	0.00	5,697.00	0.00	0.00	0.00
614	2013072038856	03/05/12 - 03/06/12	03/18/13	0.00	5,697.00	0.00	0.00	0.00
614	5213073000095	08/01/12 - 12/05/12	03/18/13	0.00	5,697.00	0.00	0.00	0.00
614	2313100000095	02/15/12 - 02/17/12	06/03/13	0.00	5,697.00	0.00	0.00	0.00
614	2013135040297	07/07/12 - 07/09/12	05/20/13	0.00	5,697.00	0.00	0.00	0.00
614	2013198017086	08/18/12 - 08/22/12	07/22/13	0.00	5,697.00	0.00	0.00	0.00
TOTAL				0.00	148,316.00	0.00	7,645.23	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: 09/24/2013  
 Run Time: 15:35:22  
 Page: 4

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,035,094.83	ADJUSTMENTS	0.00
COVERED CHARGES	1,012,105.83	CONTRACTUAL ALLOW	335,690.34
NON-COVERD CHARGES	22,989.00	TOTAL MEDICAID LIAB	676,415.49
		LESS: COB	676,415.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	141		0	156,520.00		20,920.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	141		0	156,520.00		20,920.00
SPECIAL CARE SERVICES						
CCU	12		0	47,940.00		0.00
ICU	6		0	17,325.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	18		0	65,265.00		0.00
TOTAL ACCOMODATIONS	159		0	221,785.00		20,920.00

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,153.59	0.00	OTHER LAB	1,663.00	0.00
MED/SURG SUPPLY	72,296.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	111,197.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,423.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,623.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,681.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,596.00	0.00	MRI SERVICES	38,807.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,702.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	78.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,698.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,125.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,555.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,822.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,760.00	0.00	INJECTABLE DRUGS	146,576.24	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,074.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	537.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70,307.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	961.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,785.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,142.00	2,069.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,759.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	790,320.83	2,069.00
			TOTAL ACCOMODATIONS	221,785.00	20,920.00
			TOTAL CHARGES	1,012,105.83	22,989.00

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

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

Run Date: 09/24/2013  
Run Time: 15:35:25  
Page: 6

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,398,378.24	ADJUSTMENTS	290,400.34
COVERED CHARGES	19,556,047.38	CONTRACTUAL ALLOW	14,539,555.12
NON-COVERD CHARGES	5,842,330.86	TOTAL MEDICAID LIAB	5,016,492.26
		LESS: COB	15,870.36
		LESS: COPAYMENT	13,732.76
		REIMBURSEMENT	4,986,889.14
		ALL OTHER	4,268,831.90
		FEE SCHEDULE-LAB	678,254.02
		INJECTABLE DRUGS	39,803.22
		TOTAL NUMBER OF CLAIMS	11,107

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	828,528.85	12,901.92	OTHER LAB	127,176.00	175.00
MED/SURG SUPPLY	838,001.44	42,502.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	722.00	EDUCATION & TRAINING	0.00	1,263.00
RADIOLOGY-DIAGNOSTIC	786,287.00	39,771.00	OTHER THERAPEUTIC SVC	0.00	135,470.00
CT SCAN	2,233,067.00	584,046.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	125,304.00	65,516.00	FEE SCHEDULE LAB	4,481,595.69	1,138,846.37
EKG/ECG	100,547.00	708.00	MRI SERVICES	4,442,571.00	871,063.00
IV THERAPY	4,355.00	392.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,075,511.00	703,707.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,837.00	4,762.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	256,677.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	65,850.00	31,377.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,095,320.50	70,781.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,135.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	171,927.90	405,639.03
RADIOLOGY THERAPEUTIC	7,681.00	850.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	86,058.00	66,681.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	56,637.00	36,190.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,485.00	PATIENT CONVENIENCE	0.00	21.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,744.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	102,811.00	376,922.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	127,525.00
OTHER IMAGING SERVICE	1,010,165.00	426,772.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,544.00	643.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	247,896.00	209,348.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	542,506.00	449,951.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,985.00	0.00			
ORGAN ACQUISITION	0.00	13,531.25			
TREATMENT/OBSERV. RM	577,073.00	13,025.00			
			TOTAL ANCILLARY	19,556,047.38	5,842,330.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,556,047.38	5,842,330.86

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012139057579	05/10/12 - 05/10/12	05/21/12	0.00	5,091.00	0.00	0.00	0.00
614	2012180051600	06/20/12 - 06/20/12	07/02/12	0.00	194.00	0.00	0.00	0.00
614	2012188028750	06/27/12 - 06/27/12	07/09/12	0.00	5,697.00	0.00	0.00	0.00
614	2012191010682	06/30/12 - 06/30/12	07/16/12	0.00	5,697.00	0.00	0.00	0.00
614	2012198009706	06/29/12 - 06/29/12	07/23/12	0.00	5,697.00	0.00	0.00	0.00
614	2012205011467	07/13/12 - 07/13/12	07/30/12	0.00	5,697.00	0.00	0.00	0.00
614	2012208023480	07/13/12 - 07/13/12	07/30/12	0.00	5,697.00	0.00	0.00	0.00
614	2012208023495	07/18/12 - 07/18/12	07/30/12	0.00	5,697.00	0.00	0.00	0.00
614	2012222010976	07/02/12 - 07/02/12	08/13/12	0.00	5,697.00	0.00	0.00	0.00
615	2012222121596	01/18/12 - 01/18/12	08/13/12	0.00	2,603.00	0.00	0.00	0.00
614	2012226039601	08/04/12 - 08/04/12	08/20/12	0.00	5,697.00	0.00	0.00	0.00
614	2012233011265	08/10/12 - 08/10/12	08/27/12	0.00	5,697.00	0.00	0.00	0.00
614	2012235033565	08/13/12 - 08/13/12	08/27/12	0.00	5,697.00	0.00	0.00	0.00
614	2012236045841	08/15/12 - 08/15/12	08/27/12	0.00	5,697.00	0.00	0.00	0.00
614	2012237026898	08/15/12 - 08/15/12	08/27/12	0.00	5,697.00	0.00	0.00	0.00
614	2012254036988	08/30/12 - 08/30/12	09/17/12	0.00	5,697.00	0.00	0.00	0.00
614	2012254037006	08/31/12 - 08/31/12	09/17/12	0.00	5,697.00	0.00	0.00	0.00
614	1112255003134	03/17/12 - 03/17/12	09/17/12	0.00	5,697.00	0.00	212.89	0.00
614	2012262066956	03/14/12 - 03/14/12	09/24/12	0.00	5,697.00	0.00	0.00	0.00
614	2012275012480	06/28/12 - 06/28/12	10/08/12	0.00	5,697.00	0.00	0.00	0.00
614	2212275007318	08/28/12 - 08/28/12	10/08/12	0.00	5,697.00	0.00	0.00	0.00
614	2212275008417	08/30/12 - 08/30/12	10/08/12	0.00	5,697.00	0.00	0.00	0.00
614	2012345019992	08/22/12 - 08/22/12	12/17/12	0.00	5,697.00	0.00	0.00	0.00
614	2013168011327	07/09/12 - 07/09/12	06/24/13	0.00	5,697.00	0.00	0.00	0.00
TOTAL				0.00	127,525.00	0.00	212.89	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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	763,056.76	ADJUSTMENTS	0.00
COVERED CHARGES	482,793.42	CONTRACTUAL ALLOW	73,490.32
NON-COVERD CHARGES	280,263.34	TOTAL MEDICAID LIAB	409,303.10
		LESS: COB	408,910.99
		LESS: COPAYMENT	392.11
		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

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,224.52	1,822.55	OTHER LAB	2,379.00	69.00
MED/SURG SUPPLY	22,456.00	3,827.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,274.00	516.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,416.00	32,338.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,453.00	4,540.00	FEE SCHEDULE LAB	80,136.00	21,237.00
EKG/ECG	3,658.00	118.00	MRI SERVICES	95,881.00	60,232.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,380.00	22,908.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,577.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,985.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	205.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,165.00	1,887.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,915.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,685.90	18,398.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,172.00	1,572.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	241.00	3,499.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	72.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,937.00	22,148.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,830.00	13,950.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	69.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,033.00	14,164.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,300.00	55,768.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	1,018.75			
TREATMENT/OBSERV. RM	11,421.00	179.00			
			TOTAL ANCILLARY	482,793.42	280,263.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	482,793.42	280,263.34

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

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

Run Date: 09/24/2013  
Run Time: 15:39:01  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	187,223.93	ADJUSTMENTS	270.70
COVERED CHARGES	156,562.21	CONTRACTUAL ALLOW	149,134.05
NON-COVERD CHARGES	30,661.72	TOTAL MEDICAID LIAB	7,428.16
		LESS: COB	0.00
		LESS: COPAYMENT	390.02
		REIMBURSEMENT	7,038.14
		TOTAL NUMBER OF CLAIMS	134



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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,532.52	48.72	OTHER LAB	3,580.00	0.00
MED/SURG SUPPLY	3,513.00	119.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,722.00	98.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,741.00	10,136.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,339.00	4,685.00
EKG/ECG	2,832.00	0.00	MRI SERVICES	16,835.00	13,924.00
IV THERAPY	258.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	424.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,102.00	1,176.00	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	1,467.69	296.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	756.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,179.00	179.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,281.00	0.00			
			TOTAL ANCILLARY	156,562.21	30,661.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	156,562.21	30,661.72

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,992.46	ADJUSTMENTS	0.00
COVERED CHARGES	12,774.48	CONTRACTUAL ALLOW	9,465.60
NON-COVERD CHARGES	2,217.98	TOTAL MEDICAID LIAB	3,308.88
		LESS: COB	3,290.88
		LESS: COPAYMENT	18.00
		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

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106.96	568.02	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	249.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,188.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,809.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,169.00	918.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,060.00	711.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27.52	20.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,165.00	0.00			
			TOTAL ANCILLARY	12,774.48	2,217.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,774.48	2,217.98

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

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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,225,111.99	ADJUSTMENTS	130,658.67
COVERED CHARGES	2,825,464.32	CONTRACTUAL ALLOW	2,265,601.02
NON-COVERD CHARGES	399,647.67	TOTAL MEDICAID LIAB	559,863.30
		LESS: COB	0.00
		LESS: COPAYMENT	438.00
		REIMBURSEMENT	559,425.30
		TOTAL NUMBER OF CLAIMS	90

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

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

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

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,956.43	1,737.22	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	450,546.00	8,322.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	256,580.00	38,480.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,827.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	320.00	FEE SCHEDULE LAB	68,382.00	8,884.00
EKG/ECG	2,360.00	118.00	MRI SERVICES	159,609.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	543,812.00	197,133.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,841.00	208.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	114,916.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,589.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,754.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	74,010.29	84,724.45
RADIOLOGY THERAPEUTIC	504.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	310.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	897,340.60	40,611.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,631.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,215.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,694.00	152.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,803.00	18,648.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,094.00	0.00			
			TOTAL ANCILLARY	2,825,464.32	399,647.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,825,464.32	399,647.67

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

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

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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	397,010.05	ADJUSTMENTS	0.00
COVERED CHARGES	318,835.56	CONTRACTUAL ALLOW	63,005.05
NON-COVERD CHARGES	78,174.49	TOTAL MEDICAID LIAB	255,830.51
		LESS: COB	255,797.51
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIV HOSPPT FINANCIALSERV  
 1364 CLIFTON RD NE DEPT RM  
 ATLANTA,GA 30322-1059

PROVIDER NUMBER  
 000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,135.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,590.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	228.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,828.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,901.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,948.00	74,124.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,260.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,570.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	648.55	214.49
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	241,390.00	1,008.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
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	318,835.56	78,174.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	318,835.56	78,174.49

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER 000000723A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	122,202,506.98	ADJUSTMENTS	10,668,101.50
COVERED CHARGES	117,725,784.91	CONTRACTUAL ALLOW	80,396,866.90
NON-COVERD CHARGES	4,476,722.07	TOTAL MEDICAID LIAB	37,328,918.01
		LESS: COB	288,295.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	37,040,622.61

TOTAL NUMBER OF ADMISSIONS 2,875

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	13,381	264	8,519,836.00	2,119,202.00
ROUTINE NURSERY	1,270	0	2,216,121.00	111,413.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	8.15
TOTAL ROUTINE	14,651	264	10,735,957.00	2,230,623.15
SPECIAL CARE SERVICES				
CCU	153	0	230,008.00	0.00
ICU	2,468	0	4,376,459.00	0.00
NICU	706	0	2,284,908.00	0.00
PED ICU	691	0	2,233,743.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	492	0	1,419,557.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,510	0	10,544,675.00	0.00
TOTAL ACCOMODATIONS	19,161	264	21,280,632.00	2,230,623.15



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,369,830.81	118,512.91	OTHER LAB	378,804.00	7,144.00
MED/SURG SUPPLY	10,982,221.00	197,316.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,495,976.50	148,120.00	EDUCATION & TRAINING	7,147.00	693.00
RADIOLOGY-DIAGNOSTIC	2,902,587.00	3,894.00	OTHER THERAPEUTIC SVC	132,422.00	11,358.00
CT SCAN	1,811,800.50	1,200,790.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	554,995.00	2,882.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	162,488.00	0.00	MRI SERVICES	785,449.00	0.00
IV THERAPY	443,972.00	18,635.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,785,488.00	24,081.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	278,730.00	639.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,782,968.50	21,692.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,297,640.00	328.00	AMBULANCE	0.00	0.00
GI SERVICES	104,580.00	0.00	CAST ROOM	240.00	0.00
EMERGENCY ROOM	2,125,750.00	4,258.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	727,099.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,257.20
LABORATORY PATHOLOGIC	1,073,158.00	754.00	INJECTABLE DRUGS	6,191,031.98	0.00
RADIOLOGY THERAPEUTIC	342,519.00	1,262.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	192,018.00	763.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	158,083.00	788.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	278,950.00	80,220.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	322.62	53,525.81	TRAUMA RESPONSE	0.00	122,409.00
PSYCHIATRIC SERVICES	1,406.00	0.00	IMPL DEV CHARGE PATIENTS	9,105,245.00	16.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,908.00
OTHER IMAGING SERVICE	360,622.50	34,694.00			
BLOOD	33,002.00	0.00			
BLOOD STORAGE & PRO.	1,944,466.00	90,684.00			
ONCOLOGY	200.00	549.00			
NUCLEAR MEDICINE	203,297.00	93,384.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,960,274.50	0.00			
AMBULATORY SURGERY	3,604.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,058,179.00	0.00			
ORGAN ACQUISITION	231,780.00	0.00			
TREATMENT/OBSERV. RM	176,806.00	1,542.00			
			TOTAL ANCILLARY	96,445,152.91	2,246,098.92
			TOTAL ACCOMODATIONS	21,280,632.00	2,230,623.15
			TOTAL CHARGES	117,725,784.91	4,476,722.07

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: 09/24/2013  
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MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
31	2212044000396	12/09/11 - 12/15/11	02/20/12	0.00	2,908.00	0.00	0.00	0.00
TOTAL				0.00	2,908.00	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER 000000723A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,242,425.43	ADJUSTMENTS	0.00
COVERED CHARGES	2,162,991.43	CONTRACTUAL ALLOW	1,028,281.53
NON-COVERD CHARGES	79,434.00	TOTAL MEDICAID LIAB	1,134,709.90
		LESS: COB	1,134,709.90
		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	151		0	96,640.00		23,157.00
ROUTINE NURSERY	115		0	193,680.00		26,964.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	266		0	290,320.00		50,121.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	21		0	37,182.00		0.00
NICU	23		0	72,381.00		0.00
PED ICU	78		0	251,325.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	122		0	360,888.00		0.00
TOTAL ACCOMODATIONS	388		0	651,208.00		50,121.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	265,436.50	0.00	OTHER LAB	7,764.00	0.00
MED/SURG SUPPLY	237,919.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	223,418.00	0.00	EDUCATION & TRAINING	1,022.00	0.00
RADIOLOGY-DIAGNOSTIC	39,930.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,895.00	20,102.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,730.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	744.00	0.00	MRI SERVICES	6,328.00	0.00
IV THERAPY	7,056.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,460.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,119.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	245,008.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,334.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,818.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,814.00	0.00	INJECTABLE DRUGS	47,607.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,164.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,516.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,226.00	908.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,487.00	TRAUMA RESPONSE	0.00	1,603.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,716.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,970.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,441.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,838.00	2,213.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,785.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,149.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,390.00	0.00			
			TOTAL ANCILLARY	1,511,783.43	29,313.00
			TOTAL ACCOMODATIONS	651,208.00	50,121.00
			TOTAL CHARGES	2,162,991.43	79,434.00

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: 09/24/2013  
Run Time: 15:41:09  
Page: 6

MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,794,601.69	ADJUSTMENTS	2,768,903.68
COVERED CHARGES	44,083,323.45	CONTRACTUAL ALLOW	32,226,977.66
NON-COVERD CHARGES	5,711,278.24	TOTAL MEDICAID LIAB	11,856,345.79
		LESS: COB	72,222.29
		LESS: COPAYMENT	59,779.11
		REIMBURSEMENT	11,724,344.39
		ALL OTHER	9,771,720.16
		FEE SCHEDULE-LAB	910,223.09
		INJECTABLE DRUGS	1,042,401.14
		TOTAL NUMBER OF CLAIMS	38,582

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,740,867.99	72,999.61	OTHER LAB	683,685.00	37,846.00
MED/SURG SUPPLY	1,897,297.00	52,667.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	536.00	EDUCATION & TRAINING	7,457.00	1,596.00
RADIOLOGY-DIAGNOSTIC	1,565,404.34	62,992.00	OTHER THERAPEUTIC SVC	21,641.00	8,523.00
CT SCAN	2,340,728.00	192,387.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,229.00	28,419.00	FEE SCHEDULE LAB	8,155,872.06	1,203,651.56
EKG/ECG	192,117.00	0.00	MRI SERVICES	1,253,122.00	71,165.00
IV THERAPY	668,150.00	5,956.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,617,406.48	606,717.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	108,962.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	718,587.00	15,992.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,092,197.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	118,707.50	17,837.50	CAST ROOM	19,701.00	0.00
EMERGENCY ROOM	3,232,893.00	7,164.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,243,760.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	239.60
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,474,274.78	1,159,551.84
RADIOLOGY THERAPEUTIC	1,638,741.00	6,253.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,687.00	5,530.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	31,297.00	12,014.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,007.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,887,851.90	56,658.84	TRAUMA RESPONSE	0.00	49,948.00
PSYCHIATRIC SERVICES	136,365.00	4,492.00	IMPL DEV CHARGE PATIENTS	273,629.00	1,367,882.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,285,615.00	80,088.00			
BLOOD	6,828.00	0.00			
BLOOD STORAGE & PRO.	337,476.00	14,009.00			
ONCOLOGY	40,396.00	848.00			
NUCLEAR MEDICINE	525,953.00	43,889.00			
AUDIOLOGY	12,539.00	16,440.00			
CARDIOLOGY	728,867.00	480,142.00			
AMBULATORY SURGERY	3,713.00	0.00			
OSTEOPATHIC SERVICES	0.00	234.00			
E E G	505,440.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	399,866.40	23,603.00			
			TOTAL ANCILLARY	44,083,323.45	5,711,278.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	44,083,323.45	5,711,278.24

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,024,134.82	ADJUSTMENTS	0.00
COVERED CHARGES	1,388,164.63	CONTRACTUAL ALLOW	397,238.69
NON-COVERD CHARGES	635,970.19	TOTAL MEDICAID LIAB	990,925.94
		LESS: COB	990,246.93
		LESS: COPAYMENT	679.01
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,068

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

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,893.29	4,442.54	OTHER LAB	34,057.00	4,780.00
MED/SURG SUPPLY	90,574.00	5,103.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,651.00	3,326.00	OTHER THERAPEUTIC SVC	0.00	1,665.00
CT SCAN	44,815.00	7,382.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	813.00	1,354.00	FEE SCHEDULE LAB	217,688.65	39,147.40
EKG/ECG	4,944.00	0.00	MRI SERVICES	11,412.00	3,789.00
IV THERAPY	27,477.00	3,243.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	155,512.25	75,401.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,111.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,604.00	1,288.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,212.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	1,179.00	0.00
EMERGENCY ROOM	75,790.00	62.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,281.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	202,502.44	117,737.61
RADIOLOGY THERAPEUTIC	34,166.00	212.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,162.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,723.00	1,010.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	57,298.00	2,067.86	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,065.00	398.00	IMPL DEV CHARGE PATIENTS	1,361.00	307,746.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	500.00
OTHER IMAGING SERVICE	28,562.00	11,984.00			
BLOOD	1,707.00	0.00			
BLOOD STORAGE & PRO.	8,216.00	0.00			
ONCOLOGY	200.00	0.00			
NUCLEAR MEDICINE	8,845.00	3,952.00			
AUDIOLOGY	0.00	82.00			
CARDIOLOGY	26,617.00	39,297.00			
AMBULATORY SURGERY	1,802.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,435.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,489.00	0.00			
			TOTAL ANCILLARY	1,388,164.63	635,970.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,388,164.63	635,970.19



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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3361	5912151001658	04/27/12 - 04/27/12	06/04/12	0.00	500.00	0.00	62.19	0.00
TOTAL				0.00	500.00	0.00	62.19	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: 09/24/2013  
Run Time: 15:47:20  
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MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,708,674.38	ADJUSTMENTS	3,413.99
COVERED CHARGES	1,621,479.32	CONTRACTUAL ALLOW	1,510,929.32
NON-COVERD CHARGES	87,195.06	TOTAL MEDICAID LIAB	110,550.00
		LESS: COB	253.60
		LESS: COPAYMENT	4,173.01
		REIMBURSEMENT	106,123.39
		TOTAL NUMBER OF CLAIMS	2,211

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,243.39	4,504.89	OTHER LAB	3,520.00	1,902.00
MED/SURG SUPPLY	26,473.00	577.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	21.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	89,665.00	1,513.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	116,331.00	9,923.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	588.00	865.00	FEE SCHEDULE LAB	226,172.00	34,458.80
EKG/ECG	9,400.00	0.00	MRI SERVICES	22,608.00	1,964.00
IV THERAPY	55,504.00	409.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,123.00	5,833.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,173.00	238.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,931.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	846,854.00	186.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,811.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,713.93	7,803.32
RADIOLOGY THERAPEUTIC	349.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	629.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	294.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,429.00	94.05	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,187.00	1,748.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,853.00	1,458.00			
BLOOD	1,138.00	0.00			
BLOOD STORAGE & PRO.	1,045.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	480.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,496.00	12,774.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,392.00	0.00			
			TOTAL ANCILLARY	1,621,479.32	87,195.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,621,479.32	87,195.06

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: 09/24/2013  
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MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,588.95	ADJUSTMENTS	0.00
COVERED CHARGES	54,592.69	CONTRACTUAL ALLOW	39,859.19
NON-COVERD CHARGES	8,996.26	TOTAL MEDICAID LIAB	14,733.50
		LESS: COB	14,676.50
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	43

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

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

Run Date: 09/24/2013  
 Run Time: 15:47:46  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,435.69	150.00	OTHER LAB	609.00	0.00
MED/SURG SUPPLY	478.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,242.00	451.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,694.00	1,139.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	294.00	FEE SCHEDULE LAB	9,724.00	1,799.00
EKG/ECG	128.00	0.00	MRI SERVICES	4,457.00	1,839.00
IV THERAPY	4,591.00	950.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	417.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,768.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	891.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15.00	442.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	169.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	571.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	20.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	541.00	1,172.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	923.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,441.00	0.00			
			TOTAL ANCILLARY	54,592.69	8,996.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,592.69	8,996.26

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

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

Run Date: 09/24/2013  
Run Time: 15:48:01  
Page: 15

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,807,440.87	ADJUSTMENTS	749,915.86
COVERED CHARGES	9,932,302.50	CONTRACTUAL ALLOW	8,371,375.12
NON-COVERD CHARGES	875,138.37	TOTAL MEDICAID LIAB	1,560,927.38
		LESS: COB	5,175.03
		LESS: COPAYMENT	1,692.00
		REIMBURSEMENT	1,554,060.35
		TOTAL NUMBER OF CLAIMS	287

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

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	534,953.98	6,435.44	OTHER LAB	5,992.00	454.00
MED/SURG SUPPLY	939,681.00	79,010.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	144,935.00	9,389.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,488.00	5,955.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	865.00	5,089.00	FEE SCHEDULE LAB	211,880.83	53,457.30
EKG/ECG	4,320.00	0.00	MRI SERVICES	4,355.00	18,255.00
IV THERAPY	18,555.00	151.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	579,996.11	130,250.21	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65,881.00	2,818.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	243,474.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,963.00	1,193.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	118,525.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,234,364.08	131,890.92
RADIOLOGY THERAPEUTIC	1,327,671.00	10,852.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	159.00	3,285.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,753.00	2,487.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,075,441.00	156,959.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,953.00	882.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,323.00	0.00			
ONCOLOGY	7,675.00	0.00			
NUCLEAR MEDICINE	9,237.00	752.00			
AUDIOLOGY	1,830.00	4,745.00			
CARDIOLOGY	1,209,122.50	250,828.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,572.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,337.00	0.00			
			TOTAL ANCILLARY	9,932,302.50	875,138.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,932,302.50	875,138.37

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

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

Run Date: 09/24/2013  
Run Time: 15:48:20  
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	171,067.96	ADJUSTMENTS	0.00
COVERED CHARGES	146,652.20	CONTRACTUAL ALLOW	50,838.35
NON-COVERD CHARGES	24,415.76	TOTAL MEDICAID LIAB	95,813.85
		LESS: COB	95,810.85
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4



SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,238.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,845.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,285.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	390.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,804.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,802.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,727.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,657.44	1,788.76
RADIOLOGY THERAPEUTIC	292.00	57.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	63.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	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	69,548.00	22,570.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	146,652.20	24,415.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	146,652.20	24,415.76

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

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

Run Date: 09/24/2013  
 Run Time: 15:48:41  
 Page: 1

EVANS MEMORIAL HOSPITAL  
 200 N RIVER ST  
 CLAXTON,GA 30417-1659

PROVIDER NUMBER 000000734A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,232,288.44	ADJUSTMENTS	0.00
COVERED CHARGES	1,169,661.44	CONTRACTUAL ALLOW	706,802.58
NON-COVERD CHARGES	62,627.00	TOTAL MEDICAID LIAB	462,858.86
		LESS: COB	43,473.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	419,385.36
		TOTAL NUMBER OF ADMISSIONS	70

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	182	0	146,346.00	55,134.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	182	0	146,346.00	55,134.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	93	0	129,390.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	93	0	129,390.00	0.00
TOTAL ACCOMODATIONS	275	0	275,736.00	55,134.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	161,550.50	0.00	OTHER LAB	2,550.00	0.00
MED/SURG SUPPLY	111,788.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	323,560.00	0.00	EDUCATION & TRAINING	525.00	0.00
RADIOLOGY-DIAGNOSTIC	35,245.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,055.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,105.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,100.00	0.00	MRI SERVICES	5,860.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,195.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,110.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,030.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,951.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	330.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,450.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,240.00	6,958.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,890.00	535.00			
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	1,140.00	0.00			
			TOTAL ANCILLARY	893,925.44	7,493.00
			TOTAL ACCOMODATIONS	275,736.00	55,134.00
			TOTAL CHARGES	1,169,661.44	62,627.00

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

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

Run Date: 09/24/2013  
Run Time: 15:48:44  
Page: 3

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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 15:48:44  
Page: 4

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,571,910.97	ADJUSTMENTS	44,170.30
COVERED CHARGES	1,473,579.14	CONTRACTUAL ALLOW	1,180,052.92
NON-COVERD CHARGES	98,331.83	TOTAL MEDICAID LIAB	293,526.22
		LESS: COB	1,561.86
		LESS: COPAYMENT	1,293.00
		REIMBURSEMENT	290,671.36
		ALL OTHER	266,043.14
		FEE SCHEDULE-LAB	23,421.52
		INJECTABLE DRUGS	1,206.70
		TOTAL NUMBER OF CLAIMS	1,263

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

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

Run Date: 09/24/2013  
 Run Time: 15:48:44  
 Page: 5

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,992.00	125.00	OTHER LAB	4,420.00	0.00
MED/SURG SUPPLY	45,433.14	923.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	330.00	EDUCATION & TRAINING	0.00	150.00
RADIOLOGY-DIAGNOSTIC	120,585.00	900.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	218,265.00	1,845.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,565.00	200.00	FEE SCHEDULE LAB	314,285.00	61,114.50
EKG/ECG	21,875.00	720.00	MRI SERVICES	104,120.00	2,930.00
IV THERAPY	25,340.00	3,035.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	72,520.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,450.00	55.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	34,425.00	5,400.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	332,824.00	7,450.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,950.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,960.00	9,314.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	990.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,060.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,965.00	795.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,180.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,755.00	1,425.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,300.00	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	26,320.00	1,620.00			
			TOTAL ANCILLARY	1,473,579.14	98,331.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,473,579.14	98,331.83

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

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

Run Date: 09/24/2013  
Run Time: 15:49:13  
Page: 6

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,476.30	ADJUSTMENTS	0.00
COVERED CHARGES	17,347.30	CONTRACTUAL ALLOW	4,372.46
NON-COVERD CHARGES	5,129.00	TOTAL MEDICAID LIAB	12,974.84
		LESS: COB	12,944.84
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	305.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	667.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,845.00	3,885.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,605.00	309.00
EKG/ECG	360.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,400.00	270.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	155.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	565.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	570.00	0.00			
			TOTAL ANCILLARY	17,347.30	5,129.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,347.30	5,129.00



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: 09/24/2013  
Run Time: 15:49:14  
Page: 8

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,747.57	ADJUSTMENTS	161.82
COVERED CHARGES	68,775.57	CONTRACTUAL ALLOW	62,734.05
NON-COVERD CHARGES	1,972.00	TOTAL MEDICAID LIAB	6,041.52
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	5,858.52
		TOTAL NUMBER OF CLAIMS	108

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	715.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	130.57	10.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,480.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,535.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,935.00	712.00
EKG/ECG	180.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	250.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,295.00	540.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,740.00	325.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,515.00	385.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	68,775.57	1,972.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,775.57	1,972.00

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: 09/24/2013  
Run Time: 15:49:16  
Page: 10

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	10/01/11	THROUGH	09/30/12
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

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	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:49:25  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER  
 304 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER 000000756A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,972,134.06	ADJUSTMENTS	3,952,421.73
COVERED CHARGES	47,935,253.88	CONTRACTUAL ALLOW	34,579,349.13
NON-COVERD CHARGES	2,036,880.18	TOTAL MEDICAID LIAB	13,355,904.75
		LESS: COB	203,888.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,152,016.73

TOTAL NUMBER OF ADMISSIONS 1,890

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,885		0	3,234,568.15		862,160.00
ROUTINE NURSERY	1,045		0	814,385.00		10,890.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,930		0	4,048,953.15		873,050.00
SPECIAL CARE SERVICES						
CCU	1,672		0	1,417,680.00		0.00
ICU	1,470		0	1,857,035.00		0.00
NICU	208		0	384,384.00		0.00
PED ICU	40		0	48,400.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,390		0	3,707,499.00		0.00
TOTAL ACCOMODATIONS	10,320		0	7,756,452.15		873,050.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,243,660.16	15,781.65	OTHER LAB	209,453.00	0.00
MED/SURG SUPPLY	4,820,443.31	161,977.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,371,660.33	20,009.00	EDUCATION & TRAINING	5,664.00	72.00
RADIOLOGY-DIAGNOSTIC	667,575.00	3,256.00	OTHER THERAPEUTIC SVC	0.00	144.00
CT SCAN	817,186.00	518,532.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118,212.00	315.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	720,316.00	195.00	MRI SERVICES	312,494.00	0.00
IV THERAPY	161,040.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,613,889.00	26,406.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,098,562.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,570,837.00	20,877.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	650,433.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,000,287.08	17,264.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	422,653.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	90,166.00
LABORATORY PATHOLOGIC	154,376.80	459.00	INJECTABLE DRUGS	1,180,842.30	46,836.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,870.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	37,774.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	276,200.00	29,931.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,861.00	1,246.00	TRAUMA RESPONSE	0.00	30,960.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,532,155.75	1,950.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,388.00
OTHER IMAGING SERVICE	194,133.00	35,889.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	413,242.00	99,012.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	218,265.00	35,403.00			
AUDIOLOGY	24,776.00	0.00			
CARDIOLOGY	1,168,340.00	2,451.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,533.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	110,068.00	2,310.00			
			TOTAL ANCILLARY	40,178,801.73	1,163,830.18
			TOTAL ACCOMODATIONS	7,756,452.15	873,050.00
			TOTAL CHARGES	47,935,253.88	2,036,880.18

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

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

Run Date: 09/24/2013  
Run Time: 15:49:25  
Page: 3

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
703	2212020011885	01/05/12 - 01/09/12	01/23/12	0.00	1,188.00	0.00	0.00	0.00
-1	9712111964028	11/04/11 - 11/07/11	04/30/12	0.00	1,200.00	0.00	0.00	0.00
TOTAL				0.00	2,388.00	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: 09/24/2013  
 Run Time: 15:50:24  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER  
 304 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER 000000756A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	742,774.41	ADJUSTMENTS	0.00
COVERED CHARGES	728,595.41	CONTRACTUAL ALLOW	402,655.10
NON-COVERD CHARGES	14,179.00	TOTAL MEDICAID LIAB	325,940.31
		LESS: COB	325,940.31
		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	102		0	56,100.00		11,110.00
ROUTINE NURSERY	71		0	85,250.00		100.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	173		0	141,350.00		11,210.00
SPECIAL CARE SERVICES						
CCU	2		0	1,650.00		0.00
ICU	4		0	3,300.00		0.00
NICU	14		0	25,872.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	30,822.00		0.00
TOTAL ACCOMODATIONS	193		0	172,172.00		11,210.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,562.75	0.00	OTHER LAB	7,012.00	0.00
MED/SURG SUPPLY	83,812.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	68,940.24	0.00	EDUCATION & TRAINING	74.00	0.00
RADIOLOGY-DIAGNOSTIC	14,822.48	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,596.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	780.00	0.00	MRI SERVICES	3,371.00	0.00
IV THERAPY	15,873.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,086.53	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	93,250.00	1,200.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,342.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,927.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,136.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,235.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	102.00	0.00	INJECTABLE DRUGS	12,133.20	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	238.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,459.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	119.00
OTHER IMAGING SERVICE	5,167.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,424.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,120.00	0.00			
CARDIOLOGY	7,000.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,960.00	0.00			
			TOTAL ANCILLARY	556,423.41	2,969.00
			TOTAL ACCOMODATIONS	172,172.00	11,210.00
			TOTAL CHARGES	728,595.41	14,179.00

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: 09/24/2013  
Run Time: 15:50:24  
Page: 6

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
616	2212340013049	09/04/11 - 09/04/11	12/10/12	0.00	50.00	0.00	6,182.71	0.00
618	2212340013049	09/05/11 - 09/05/11	12/10/12	0.00	69.00	0.00	6,182.71	0.00
TOTAL				0.00	119.00	0.00	12,365.42	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: 09/24/2013  
Run Time: 15:50:31  
Page: 7

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,877,695.59	ADJUSTMENTS	836,887.52
COVERED CHARGES	28,297,559.75	CONTRACTUAL ALLOW	22,818,531.74
NON-COVERD CHARGES	3,580,135.84	TOTAL MEDICAID LIAB	5,479,028.01
		LESS: COB	17,682.11
		LESS: COPAYMENT	9,211.03
		REIMBURSEMENT	5,452,134.87
		ALL OTHER	4,586,065.38
		FEE SCHEDULE-LAB	544,160.11
		INJECTABLE DRUGS	321,909.38

TOTAL NUMBER OF CLAIMS 12,858

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	751,318.97	4,723.25	OTHER LAB	135,617.00	3,879.00
MED/SURG SUPPLY	2,777,505.69	13,427.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,200.00	EDUCATION & TRAINING	7,348.00	360.00
RADIOLOGY-DIAGNOSTIC	1,035,250.00	29,078.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,713,468.00	467,064.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	148,341.00	52,968.00	FEE SCHEDULE LAB	4,750,491.86	594,792.80
EKG/ECG	397,054.00	22,387.00	MRI SERVICES	428,951.00	47,277.00
IV THERAPY	883,378.00	138,078.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,278,174.00	1,049,757.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	184,187.00	617.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	131,486.00	14,924.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	586,905.00	754.00	AMBULANCE	0.00	0.00
GI SERVICES	2,760.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,603,184.00	91,674.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	660,970.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	660.00
LABORATORY PATHOLOGIC	0.00	1,393.00	INJECTABLE DRUGS	2,915,712.23	791,050.50
RADIOLOGY THERAPEUTIC	140.00	0.00	HOME HEALTH SERVICES	0.00	41.00
OCCUPATIONAL THERAPY	0.00	1,290.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	684.00	1,520.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,833.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	104,668.00	5,348.00	TRAUMA RESPONSE	0.00	50,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	300,320.00	142.00
LITHOTRIPSY	139,520.00	0.00	NO CC/INVALID REV CODE	0.00	2,130.00
OTHER IMAGING SERVICE	363,546.00	28,800.00			
BLOOD	16,497.00	21,599.00			
BLOOD STORAGE & PRO.	48,070.00	26,400.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	376,268.00	39,298.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	537,313.00	63,861.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	178,116.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	840,316.00	5,852.00			
			TOTAL ANCILLARY	28,297,559.75	3,576,577.84
			TOTAL ACCOMODATIONS	0.00	3,558.00
			TOTAL CHARGES	28,297,559.75	3,580,135.84

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

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

Run Date: 09/24/2013  
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FLOYD MEDICAL CENTER  
 304 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER  
 000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2211278010926	07/01/11 - 07/01/11	10/10/11	0.00	167.00	0.00	0.00	0.00
8010	2212030001991	12/19/11 - 12/19/11	02/06/12	0.00	56.00	0.00	0.00	0.00
8006	2212062021193	01/18/12 - 01/18/12	03/05/12	0.00	158.00	0.00	0.00	0.00
836	2212156003614	04/27/12 - 04/27/12	06/11/12	0.00	220.00	0.00	0.00	0.00
8004	5912209000668	05/30/12 - 05/30/12	07/30/12	0.00	229.00	0.00	0.00	0.00
363	5912241000281	06/26/12 - 06/26/12	09/03/12	0.00	1,300.00	0.00	0.00	0.00
TOTAL				0.00	2,130.00	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: 09/24/2013  
Run Time: 15:53:04  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	873,380.73	ADJUSTMENTS	0.00
COVERED CHARGES	779,489.43	CONTRACTUAL ALLOW	387,266.68
NON-COVERD CHARGES	93,891.30	TOTAL MEDICAID LIAB	392,222.75
		LESS: COB	392,120.44
		LESS: COPAYMENT	102.31
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 288

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,233.75	0.00	OTHER LAB	8,349.00	0.00
MED/SURG SUPPLY	73,860.54	19.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	195.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,393.00	535.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	54,666.00	16,908.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	76.00	FEE SCHEDULE LAB	129,503.00	7,422.00
EKG/ECG	5,031.00	0.00	MRI SERVICES	10,401.00	0.00
IV THERAPY	32,974.00	6,257.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,396.40	21,470.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,257.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	850.00	600.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,783.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,760.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	165,974.00	1,587.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,645.24	0.00	DRUG-SPECIFIC/HOME IV	30.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,453.50	21,662.90
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	304.00	304.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	504.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	549.00	34.00	TRAUMA RESPONSE	0.00	12,240.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,167.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,725.00	3,100.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	897.00	550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,897.00	427.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,573.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,252.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,565.00	0.00			
			TOTAL ANCILLARY	779,489.43	93,891.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	779,489.43	93,891.30



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

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

Run Date: 09/24/2013  
Run Time: 15:53:16  
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FLOYD MEDICAL CENTER  
304 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,007,261.25	ADJUSTMENTS	12,330.27
COVERED CHARGES	1,951,550.50	CONTRACTUAL ALLOW	1,875,287.98
NON-COVERD CHARGES	55,710.75	TOTAL MEDICAID LIAB	76,262.52
		LESS: COB	856.88
		LESS: COPAYMENT	3,621.20
		REIMBURSEMENT	71,784.44
		TOTAL NUMBER OF CLAIMS	1,710

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,916.75	9.00	OTHER LAB	958.00	0.00
MED/SURG SUPPLY	63,117.72	245.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,840.00	EDUCATION & TRAINING	36.00	0.00
RADIOLOGY-DIAGNOSTIC	120,718.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,492.00	12,792.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	305,270.00	16,021.00
EKG/ECG	16,965.00	0.00	MRI SERVICES	6,661.00	0.00
IV THERAPY	37,395.00	4,742.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,924.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	325.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,786.00	300.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	754.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,235,894.03	4,009.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,422.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	89,232.00	9,692.75
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	362.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,510.00	1,136.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,736.00	0.00			
			TOTAL ANCILLARY	1,951,550.50	55,710.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,951,550.50	55,710.75

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

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

Run Date: 09/24/2013  
Run Time: 15:53:52  
Page: 14

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	106,666.75	ADJUSTMENTS	0.00
COVERED CHARGES	104,860.75	CONTRACTUAL ALLOW	56,706.87
NON-COVERD CHARGES	1,806.00	TOTAL MEDICAID LIAB	48,153.88
		LESS: COB	48,105.88
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	35

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,934.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,595.00	60.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	299.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,957.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,645.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	350.00	FEE SCHEDULE LAB	16,447.00	203.00
EKG/ECG	793.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,852.00	308.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,464.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	186.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,508.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,653.00	115.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	899.00	0.00	DRUG-SPECIFIC/HOME IV	660.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,034.75	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	157.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,162.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,914.00	132.00			
			TOTAL ANCILLARY	104,860.75	1,806.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	104,860.75	1,806.00

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: 09/24/2013  
Run Time: 15:53:58  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,399,211.15	ADJUSTMENTS	111,937.88
COVERED CHARGES	3,072,942.93	CONTRACTUAL ALLOW	2,616,966.41
NON-COVERD CHARGES	326,268.22	TOTAL MEDICAID LIAB	455,976.52
		LESS: COB	0.00
		LESS: COPAYMENT	357.00
		REIMBURSEMENT	455,619.52
		TOTAL NUMBER OF CLAIMS	90

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,411.25	1.50	OTHER LAB	30,524.00	1,297.00
MED/SURG SUPPLY	354,779.55	237.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	109.00	EDUCATION & TRAINING	108.00	36.00
RADIOLOGY-DIAGNOSTIC	16,929.00	20,874.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,600.00	10,581.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	150.00	FEE SCHEDULE LAB	41,214.60	4,892.40
EKG/ECG	3,183.00	1,182.00	MRI SERVICES	0.00	0.00
IV THERAPY	52,468.00	10,186.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	484,430.18	183,665.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,211.00	3,240.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,068.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,472.00	1,417.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,410.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,247,769.35	70,271.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	82.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	480,931.00	142.00
LITHOTRIPSY	27,904.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	573.00	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	6,014.00	17,339.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,943.00	0.00			
			TOTAL ANCILLARY	3,072,942.93	326,268.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,072,942.93	326,268.22

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER  
304 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,164.50	ADJUSTMENTS	0.00
COVERED CHARGES	60,350.50	CONTRACTUAL ALLOW	23,986.42
NON-COVERD CHARGES	1,814.00	TOTAL MEDICAID LIAB	36,364.08
		LESS: COB	36,358.08
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER  
 304 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER  
 000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,443.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,656.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	205.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,409.00	34.00
EKG/ECG	299.00	195.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,105.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,163.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	588.00	1,585.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,362.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	60,350.50	1,814.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,350.50	1,814.00



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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,668,691.99	ADJUSTMENTS	2,901,145.61
COVERED CHARGES	29,350,519.74	CONTRACTUAL ALLOW	22,506,102.76
NON-COVERD CHARGES	1,318,172.25	TOTAL MEDICAID LIAB	6,844,416.98
		LESS: COB	74,254.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,770,162.49

TOTAL NUMBER OF ADMISSIONS 1,179

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,498		0	3,064,512.00		480,363.00
ROUTINE NURSERY	1,445		0	1,601,130.00		396,120.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,943		0	4,665,642.00		876,483.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	433		0	1,326,563.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	433		0	1,326,563.00		0.00
TOTAL ACCOMODATIONS	5,376		0	5,992,205.00		876,483.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,906,927.95	40,891.70	OTHER LAB	94,227.00	0.00
MED/SURG SUPPLY	1,370,513.50	23,098.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,560,283.39	48,988.00	EDUCATION & TRAINING	1,300.00	0.00
RADIOLOGY-DIAGNOSTIC	554,721.00	1,580.00	OTHER THERAPEUTIC SVC	0.00	21,062.00
CT SCAN	662,313.00	6,406.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	222,749.00	8,672.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	162,863.00	774.00	MRI SERVICES	334,024.00	10,730.00
IV THERAPY	57,835.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,740,911.00	34,390.00	DURABLE MED. EQUIP.	0.00	347.00
LABOR/DELIVERY ROOM	1,125,105.00	2,371.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,810,067.00	26,716.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	229,897.00	783.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	610,299.00	5,988.00	SPECIAL SERVICES	0.00	18,616.00
RECOVERY ROOM	226,173.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	16,668.00
LABORATORY PATHOLOGIC	165,984.00	0.00	INJECTABLE DRUGS	6,012,495.90	79,823.00
RADIOLOGY THERAPEUTIC	52,514.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	85,478.00	257.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	49,324.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	149,682.00	28,409.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	764,346.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	219,796.00	38,444.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	297,760.00	13,340.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	87,086.00	12,627.00			
AUDIOLOGY	111,698.00	0.00			
CARDIOLOGY	667,087.00	708.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,673.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,062.00	0.00			
			TOTAL ANCILLARY	23,358,314.74	441,689.25
			TOTAL ACCOMODATIONS	5,992,205.00	876,483.00
			TOTAL CHARGES	29,350,519.74	1,318,172.25

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	349,141.50	ADJUSTMENTS	0.00
COVERED CHARGES	311,408.50	CONTRACTUAL ALLOW	175,265.26
NON-COVERD CHARGES	37,733.00	TOTAL MEDICAID LIAB	136,143.24
		LESS: COB	136,143.24
		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	46		0	40,918.00		8,788.00
ROUTINE NURSERY	32		0	40,304.00		28,220.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	78		0	81,222.00		37,008.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	9,399.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	9,399.00		0.00
TOTAL ACCOMODATIONS	81		0	90,621.00		37,008.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,247.00	0.00	OTHER LAB	660.00	0.00
MED/SURG SUPPLY	14,031.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,915.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,604.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,073.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	786.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	774.00	0.00	MRI SERVICES	7,636.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,139.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,717.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,775.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,498.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,318.00	0.00	SPECIAL SERVICES	0.00	725.00
RECOVERY ROOM	7,131.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,818.00	0.00	INJECTABLE DRUGS	47,978.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	476.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,388.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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.	1,398.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,932.00	0.00			
CARDIOLOGY	1,865.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	220,787.50	725.00
			TOTAL ACCOMODATIONS	90,621.00	37,008.00
			TOTAL CHARGES	311,408.50	37,733.00

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: 09/24/2013  
Run Time: 15:54:50  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,853,015.50	ADJUSTMENTS	737,032.79
COVERED CHARGES	12,245,967.30	CONTRACTUAL ALLOW	9,889,710.29
NON-COVERD CHARGES	1,607,048.20	TOTAL MEDICAID LIAB	2,356,257.01
		LESS: COB	9,111.76
		LESS: COPAYMENT	5,387.27
		REIMBURSEMENT	2,341,757.98
		ALL OTHER	2,046,202.25
		FEE SCHEDULE-LAB	107,549.29
		INJECTABLE DRUGS	188,006.44
		TOTAL NUMBER OF CLAIMS	3,690

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	539,158.80	15,343.60
MED/SURG SUPPLY	385,015.50	11,113.00
LABORATORY-GENERAL	0.00	97.00
RADIOLOGY-DIAGNOSTIC	417,086.00	23,697.00
CT SCAN	1,216,466.00	51,405.00
PHYSICAL THERAPY	50,708.00	24,157.00
EKG/ECG	92,708.00	3,612.00
IV THERAPY	397,331.00	126,512.50
OPERATING ROOM	906,229.00	138,135.00
LABOR/DELIVERY ROOM	50,128.00	1,227.00
RESPIRATORY SERVICES	93,975.00	2,703.00
ANESTHESIA	148,784.00	6,300.00
GI SERVICES	4,401.00	0.00
EMERGENCY ROOM	2,329,769.00	70,642.00
RECOVERY ROOM	166,953.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	419,166.00	9,200.00
OCCUPATIONAL THERAPY	952.00	3,660.00
SPEECH PATHOLOGY	1,194.00	6,219.00
RENAL DIALYSIS	0.00	15,352.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	90.00	1,170.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	574,419.00	64,447.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	99,357.00	13,491.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	162,915.00	12,451.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	310,335.00	57,073.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,208.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	274,845.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	160,190.00	1,974.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,020.00	116.00
OTHER THERAPEUTIC SVC	0.00	31,396.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,650,894.00	322,886.60
MRI SERVICES	334,697.00	28,972.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	212.00
DRUG-SPECIFIC/HOME IV	0.00	2,009.00
INJECTABLE DRUGS	1,340,888.00	554,709.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	115,085.00	6,766.00
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	12,245,967.30	1,607,048.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,245,967.30	1,607,048.20

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

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	327,429.50	ADJUSTMENTS	0.00
COVERED CHARGES	260,160.50	CONTRACTUAL ALLOW	124,232.63
NON-COVERD CHARGES	67,269.00	TOTAL MEDICAID LIAB	135,927.87
		LESS: COB	135,852.87
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 130

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,749.50	918.50	OTHER LAB	2,084.00	0.00
MED/SURG SUPPLY	10,025.00	48.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,106.00	844.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,794.00	17,244.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,916.00	152.00	FEE SCHEDULE LAB	53,063.00	8,071.00
EKG/ECG	1,548.00	0.00	MRI SERVICES	3,425.00	3,425.00
IV THERAPY	604.00	570.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,420.00	17,908.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,151.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	974.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,529.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,800.00	2,176.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,134.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,501.00	4,565.50
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	2,986.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,516.00	10,925.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,748.00	422.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,865.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,222.00	0.00			
			TOTAL ANCILLARY	260,160.50	67,269.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	260,160.50	67,269.00



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

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	481,047.50	ADJUSTMENTS	1,835.90
COVERED CHARGES	441,541.50	CONTRACTUAL ALLOW	423,193.22
NON-COVERD CHARGES	39,506.00	TOTAL MEDICAID LIAB	18,348.28
		LESS: COB	0.00
		LESS: COPAYMENT	492.05
		REIMBURSEMENT	17,856.23
		TOTAL NUMBER OF CLAIMS	328

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,870.00	66.50	OTHER LAB	660.00	0.00
MED/SURG SUPPLY	4,356.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,042.00	632.00	OTHER THERAPEUTIC SVC	0.00	2,044.00
CT SCAN	23,661.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	338.00	FEE SCHEDULE LAB	64,567.00	11,647.00
EKG/ECG	4,386.00	0.00	MRI SERVICES	3,425.00	3,425.00
IV THERAPY	5,545.00	6,597.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,137.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,971.00	177.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	525.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	237,233.00	3,054.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,453.00	8,696.50
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	60.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,590.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,582.00	107.00			
			TOTAL ANCILLARY	441,541.50	39,506.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	441,541.50	39,506.00

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

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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,096.50	ADJUSTMENTS	0.00
COVERED CHARGES	17,575.50	CONTRACTUAL ALLOW	10,481.63
NON-COVERD CHARGES	2,521.00	TOTAL MEDICAID LIAB	7,093.87
		LESS: COB	7,090.87
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
TOTAL NUMBER OF CLAIMS			11

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

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

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	661.00	66.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	71.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	362.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,599.00	1,124.00
EKG/ECG	258.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,915.00	285.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	709.50	343.50
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	702.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,575.50	2,521.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,575.50	2,521.00

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,003,310.00	ADJUSTMENTS	152,137.83
COVERED CHARGES	2,863,100.70	CONTRACTUAL ALLOW	2,407,607.68
NON-COVERD CHARGES	140,209.30	TOTAL MEDICAID LIAB	455,493.02
		LESS: COB	0.00
		LESS: COPAYMENT	733.12
		REIMBURSEMENT	454,759.90

TOTAL NUMBER OF CLAIMS 83

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148,883.00	695.00	OTHER LAB	1,702.00	0.00
MED/SURG SUPPLY	109,948.00	2,062.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,392.00	7,612.00	OTHER THERAPEUTIC SVC	0.00	2,482.00
CT SCAN	134,699.00	1,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,240.00	1,420.00	FEE SCHEDULE LAB	96,697.20	17,704.30
EKG/ECG	5,676.00	258.00	MRI SERVICES	0.00	0.00
IV THERAPY	121,567.00	9,509.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	218,689.00	29,677.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,513.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,973.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,966.00	2,102.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,139.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,406,198.50	53,461.00
RADIOLOGY THERAPEUTIC	224,810.00	2,336.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	30.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	149,985.00	6,620.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,416.00	491.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,493.00	1,499.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,779.00	501.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	111,659.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,676.00	0.00			
			TOTAL ANCILLARY	2,863,100.70	140,209.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,863,100.70	140,209.30

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000767A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 15:56:34  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,204,576.28	ADJUSTMENTS	460,737.97
COVERED CHARGES	3,056,218.78	CONTRACTUAL ALLOW	-202,912.30
NON-COVERD CHARGES	148,357.50	TOTAL MEDICAID LIAB	3,259,131.08
		LESS: COB	9,026.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,250,104.72

TOTAL NUMBER OF ADMISSIONS 152

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,317		0	1,809,225.00		102,300.00
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	2,317		0	1,809,225.00		102,300.00
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	2,317		0	1,809,225.00		102,300.00



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

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

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	305,782.58	12,536.00	OTHER LAB	4,670.00	0.00
MED/SURG SUPPLY	76,388.94	4,469.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	90,330.26	2,866.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,856.86	1,742.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,038.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	229,735.90	8,128.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,288.30	0.00	MRI SERVICES	10,057.00	0.00
IV THERAPY	309.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,547.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,293.00	620.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,655.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,969.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,286.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	476.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	978.00	228.00	INJECTABLE DRUGS	329.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	272,592.25	8,184.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	126,398.24	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,400.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,961.00	689.00			
BLOOD	7,008.00	0.00			
BLOOD STORAGE & PRO.	3,102.00	3,102.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,493.25			
AUDIOLOGY	292.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,246.75	0.00			
			TOTAL ANCILLARY	1,246,993.78	46,057.50
			TOTAL ACCOMODATIONS	1,809,225.00	102,300.00
			TOTAL CHARGES	3,056,218.78	148,357.50

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

ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,630.00	ADJUSTMENTS	2,847.85
COVERED CHARGES	15,617.00	CONTRACTUAL ALLOW	1,987.21
NON-COVERD CHARGES	1,013.00	TOTAL MEDICAID LIAB	13,629.79
		LESS: COB	71.01
		LESS: COPAYMENT	276.00
		REIMBURSEMENT	13,282.78
		ALL OTHER	13,188.08
		FEE SCHEDULE-LAB	94.70
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 84

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

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

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ROOSEVELT WARM SPRINGS HOSPITAL  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	329.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	772.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,706.00	714.00	FEE SCHEDULE LAB	508.00	158.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,302.00	141.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,617.00	1,013.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,617.00	1,013.00

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22.00	ADJUSTMENTS	0.00
COVERED CHARGES	22.00	CONTRACTUAL ALLOW	19.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2.83
		LESS: COB	0.00
		LESS: COPAYMENT	2.83
		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

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

ROOSEVELT WARM SPRINGS HOSPITAL  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	22.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	22.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22.00	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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ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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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ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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 HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,274,333.33	ADJUSTMENTS	10,061,019.42
COVERED CHARGES	162,259,107.74	CONTRACTUAL ALLOW	132,137,151.01
NON-COVERD CHARGES	5,015,225.59	TOTAL MEDICAID LIAB	30,121,956.73
		LESS: COB	200,064.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	29,921,892.06

TOTAL NUMBER OF ADMISSIONS 4,224

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,615		10	15,507,728.92		1,237,538.93
ROUTINE NURSERY	3,845		0	4,399,099.34		80,588.53
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		3,909.00
TOTAL ROUTINE	16,460		10	19,906,828.26		1,322,036.46
SPECIAL CARE SERVICES						
CCU	484		0	1,670,050.56		0.00
ICU	3,372		0	10,191,015.01		55,865.00
NICU	38		0	121,618.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,894		0	11,982,683.57		55,865.00
TOTAL ACCOMODATIONS	20,354		10	31,889,511.83		1,377,901.46

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,680,547.64	405,580.80	OTHER LAB	319,542.91	0.00
MED/SURG SUPPLY	13,931,115.69	741,086.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,039,022.05	150,586.00	EDUCATION & TRAINING	22,680.00	840.00
RADIOLOGY-DIAGNOSTIC	2,848,943.83	4,206.81	OTHER THERAPEUTIC SVC	247,667.78	176,640.72
CT SCAN	4,824,337.44	32,529.29	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	541,612.18	22,102.05	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	476,751.70	1,602.12	MRI SERVICES	1,176,852.39	0.00
IV THERAPY	5,184.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,484,346.88	64,771.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,883,146.90	15,510.95	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,225,316.23	7,194.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,112,869.87	7,987.58	AMBULANCE	0.00	0.00
GI SERVICES	564,103.19	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,658,907.18	63,379.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,592,419.21	8,869.63	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	524,087.80	1,479.44	INJECTABLE DRUGS	450,614.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	359,626.33	14,554.47	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	427,797.79	25,845.24	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	328,761.50	11,485.57	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,795.28	0.00	TRAUMA RESPONSE	0.00	1,068,797.70
PSYCHIATRIC SERVICES	777,097.95	0.00	IMPL DEV CHARGE PATIENTS	4,634,458.59	8,006.14
LITHOTRIPSY	25,831.24	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	817,318.53	66,886.68			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	926,017.66	709,168.89			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	930,386.98	25,998.98			
AUDIOLOGY	184,317.77	0.00			
CARDIOLOGY	2,091,190.21	2,170.55			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	104,998.18	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	148,927.82	41.67			
			TOTAL ANCILLARY	130,369,595.91	3,637,324.13
			TOTAL ACCOMODATIONS	31,889,511.83	1,377,901.46
			TOTAL CHARGES	162,259,107.74	5,015,225.59

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

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

Run Date: 09/24/2013  
 Run Time: 15:58:48  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	150,171.69	ADJUSTMENTS	0.00
COVERED CHARGES	134,322.24	CONTRACTUAL ALLOW	108,216.46
NON-COVERD CHARGES	15,849.45	TOTAL MEDICAID LIAB	26,105.78
		LESS: COB	26,105.78
		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	10		0	12,183.00		849.45
ROUTINE NURSERY	0		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	12,183.00		849.45
SPECIAL CARE SERVICES						
CCU	1		0	3,376.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	3,376.00		0.00
TOTAL ACCOMODATIONS	11		0	15,559.00		849.45

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,005.66	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,159.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,150.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	773.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,254.99	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	658.68	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,201.59	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,562.24	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,251.18	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,927.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,497.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,522.44	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	15,000.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,798.35	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	118,763.24	15,000.00
			TOTAL ACCOMODATIONS	15,559.00	849.45
			TOTAL CHARGES	134,322.24	15,849.45

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

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

Run Date: 09/24/2013  
Run Time: 15:58:51  
Page: 5

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,606,198.09	ADJUSTMENTS	1,023,313.46
COVERED CHARGES	24,368,339.57	CONTRACTUAL ALLOW	19,823,387.89
NON-COVERD CHARGES	3,237,858.52	TOTAL MEDICAID LIAB	4,544,951.68
		LESS: COB	2,625.38
		LESS: COPAYMENT	6,687.00
		REIMBURSEMENT	4,535,639.30
		ALL OTHER	4,302,462.38
		FEE SCHEDULE-LAB	170,828.71
		INJECTABLE DRUGS	62,348.21

TOTAL NUMBER OF CLAIMS 8,374

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	975,987.20	20,429.83	OTHER LAB	117,059.41	3,238.44
MED/SURG SUPPLY	1,116,276.17	61,129.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	480.00
RADIOLOGY-DIAGNOSTIC	1,732,346.82	76,210.79	OTHER THERAPEUTIC SVC	0.00	9,756.46
CT SCAN	1,842,439.62	688,991.58	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,878.08	9,008.08	FEE SCHEDULE LAB	3,649,982.32	310,084.65
EKG/ECG	395,548.80	8,691.53	MRI SERVICES	441,015.02	52,620.16
IV THERAPY	711,560.09	106,550.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,582,226.29	427,495.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,448.47	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	128,975.05	24,527.89	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,044,419.43	0.00	AMBULANCE	0.00	0.00
GI SERVICES	38,053.01	22,668.88	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,843,269.99	54,895.28	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	391,299.22	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,593.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,436,395.52	563,949.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,335.77	10,574.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,350.59	1,798.96	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,958.74	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	216,549.62	14,647.98	TRAUMA RESPONSE	0.00	170,280.00
PSYCHIATRIC SERVICES	252,528.99	0.00	IMPL DEV CHARGE PATIENTS	2,818.42	231,854.10
LITHOTRIPSY	0.00	27,639.43	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	788,786.40	76,514.65			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,962.89	24,279.32			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	378,847.79	0.00			
AUDIOLOGY	3,348.27	1,418.98			
CARDIOLOGY	346,866.33	170,214.42			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	614,436.86	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	204,327.13	55,356.09			
			TOTAL ANCILLARY	24,368,339.57	3,237,858.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,368,339.57	3,237,858.52



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: 09/24/2013  
Run Time: 16:01:06  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,626.08	ADJUSTMENTS	0.00
COVERED CHARGES	89,542.10	CONTRACTUAL ALLOW	53,926.83
NON-COVERD CHARGES	37,083.98	TOTAL MEDICAID LIAB	35,615.27
		LESS: COB	35,600.27
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

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

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,047.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,328.73	566.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,011.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,414.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,547.44	1,946.60
EKG/ECG	801.06	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,261.56	923.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,597.52	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,767.87	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,939.12	527.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,543.49	1,558.25
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	845.06	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	350.76	459.57			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,178.46	2,399.76			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,491.18	3,215.88			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,268.54	18,071.69			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,677.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	884.56	0.00			
			TOTAL ANCILLARY	89,542.10	37,083.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	89,542.10	37,083.98

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

Run Date: 09/24/2013  
Run Time: 16:01:10  
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ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,699,700.47	ADJUSTMENTS	3,451.14
COVERED CHARGES	1,614,394.81	CONTRACTUAL ALLOW	1,552,637.08
NON-COVERD CHARGES	85,305.66	TOTAL MEDICAID LIAB	61,757.73
		LESS: COB	0.00
		LESS: COPAYMENT	2,343.08
		REIMBURSEMENT	59,414.65
		TOTAL NUMBER OF CLAIMS	1,104

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,985.24	657.50	OTHER LAB	12,410.99	0.00
MED/SURG SUPPLY	26,162.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,802.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,598.58	45,180.41	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	340,496.70	10,784.84
EKG/ECG	19,702.12	801.06	MRI SERVICES	6,447.96	0.00
IV THERAPY	56,317.64	5,639.42	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,689.44	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,322.82	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,691.97	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	883,542.07	1,952.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,746.22	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,454.01	12,812.06
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	1,050.39	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	20,872.94	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,947.14	3,042.21			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,004.80	1,229.40			
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	1,199.40	2,155.47			
			TOTAL ANCILLARY	1,614,394.81	85,305.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,614,394.81	85,305.66

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

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

Run Date: 09/24/2013  
Run Time: 16:01:25  
Page: 11

SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,832.79	ADJUSTMENTS	0.00
COVERED CHARGES	2,040.06	CONTRACTUAL ALLOW	1,727.88
NON-COVERD CHARGES	792.73	TOTAL MEDICAID LIAB	312.18
		LESS: COB	312.18
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 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	1,066.48	792.73
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	973.58	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,040.06	792.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,040.06	792.73

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

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,365,344.82	ADJUSTMENTS	158,489.25
COVERED CHARGES	3,384,783.30	CONTRACTUAL ALLOW	2,881,704.30
NON-COVERD CHARGES	980,561.52	TOTAL MEDICAID LIAB	503,079.00
		LESS: COB	0.00
		LESS: COPAYMENT	300.00
		REIMBURSEMENT	502,779.00
		TOTAL NUMBER OF CLAIMS	92

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

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212,657.24	8,031.59	OTHER LAB	5,979.13	0.00
MED/SURG SUPPLY	593,635.82	48,181.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,429.99	3,589.70	OTHER THERAPEUTIC SVC	0.00	4,878.23
CT SCAN	73,689.24	7,414.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,944.80	FEE SCHEDULE LAB	182,497.67	31,676.61
EKG/ECG	18,620.66	4,974.60	MRI SERVICES	34,020.27	6,419.02
IV THERAPY	8,051.48	897.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	854,297.61	113,264.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,654.62	781.86	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	369,086.18	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,306.25	7,010.74	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	132,946.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	180,512.90	213,091.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	486.20	1,187.72	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	404.01	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	981.67	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	258.84	TRAUMA RESPONSE	0.00	13,650.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	38,359.63	469,399.61
LITHOTRIPSY	242,512.28	23,032.88	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,840.22	2,648.61			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	156,987.73	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	167,932.48	14,990.08			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,279.10	1,851.87			
			TOTAL ANCILLARY	3,384,783.30	980,561.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,384,783.30	980,561.52



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

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

Run Date: 09/24/2013  
Run Time: 16:01:32  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

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

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER 000000811A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,322,269.68	ADJUSTMENTS	117,603.67
COVERED CHARGES	1,285,519.03	CONTRACTUAL ALLOW	670,487.45
NON-COVERD CHARGES	36,750.65	TOTAL MEDICAID LIAB	615,031.58
		LESS: COB	13,004.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	602,027.18

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	270	0	235,415.00	23,327.00
ROUTINE NURSERY	85	0	70,369.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	355	0	305,784.00	23,327.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	42	0	77,038.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	42	0	77,038.00	0.00
TOTAL ACCOMODATIONS	397	0	382,822.00	23,327.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	229,041.93	3,599.65	OTHER LAB	2,161.00	0.00
MED/SURG SUPPLY	75,382.31	363.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	112,154.79	447.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,330.00	0.00	OTHER THERAPEUTIC SVC	0.00	83.00
CT SCAN	41,114.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,139.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,305.00	0.00	MRI SERVICES	8,292.00	5,832.00
IV THERAPY	11,378.00	1,660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	131,623.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,382.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,660.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	38,982.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,656.00	431.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,962.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,421.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	100.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	306.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,083.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,470.00	1,008.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,787.00	0.00			
AUDIOLOGY	2,210.00	0.00			
CARDIOLOGY	22,154.00	0.00			
AMBULATORY SURGERY	3,476.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	912.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,215.00	0.00			
			TOTAL ANCILLARY	902,697.03	13,423.65
			TOTAL ACCOMODATIONS	382,822.00	23,327.00
			TOTAL CHARGES	1,285,519.03	36,750.65

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	247,148.27	ADJUSTMENTS	0.00
COVERED CHARGES	242,719.27	CONTRACTUAL ALLOW	86,152.95
NON-COVERD CHARGES	4,429.00	TOTAL MEDICAID LIAB	156,566.32
		LESS: COB	156,566.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	70		0	62,408.00		4,429.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	70		0	62,408.00		4,429.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	9,205.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	9,205.00		0.00
TOTAL ACCOMODATIONS	75		0	71,613.00		4,429.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,558.61	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	17,173.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,642.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,704.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,014.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	261.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	378.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,242.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,959.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,280.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,971.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,600.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,145.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,700.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,730.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,048.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,494.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	880.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,864.00	0.00			
			TOTAL ANCILLARY	171,106.27	0.00
			TOTAL ACCOMODATIONS	71,613.00	4,429.00
			TOTAL CHARGES	242,719.27	4,429.00

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

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

Run Date: 09/24/2013  
Run Time: 16:01:55  
Page: 5

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,940,109.00	ADJUSTMENTS	239,388.93
COVERED CHARGES	2,740,497.16	CONTRACTUAL ALLOW	1,898,232.94
NON-COVERD CHARGES	199,611.84	TOTAL MEDICAID LIAB	842,264.22
		LESS: COB	1,639.87
		LESS: COPAYMENT	2,700.00
		REIMBURSEMENT	837,924.35
		ALL OTHER	688,171.81
		FEE SCHEDULE-LAB	94,514.07
		INJECTABLE DRUGS	55,238.47

TOTAL NUMBER OF CLAIMS 2,674

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,760.65	1,794.21	OTHER LAB	36,177.00	0.00
MED/SURG SUPPLY	94,880.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	238.04	EDUCATION & TRAINING	282.00	0.00
RADIOLOGY-DIAGNOSTIC	157,135.00	12,036.00	OTHER THERAPEUTIC SVC	0.00	3,493.00
CT SCAN	263,646.00	13,116.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,063.00	2,571.00	FEE SCHEDULE LAB	426,092.92	74,026.20
EKG/ECG	40,948.00	189.00	MRI SERVICES	71,652.00	3,380.00
IV THERAPY	122,466.00	6,462.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,108.85	16,042.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,100.00	1,800.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,932.00	2,929.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,517.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	652,292.00	19,198.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,695.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	298,507.30	31,371.53
RADIOLOGY THERAPEUTIC	32,768.00	927.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	824.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	328.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	36.20
OTHER IMAGING SERVICE	87,909.00	3,580.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,974.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,260.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,928.00	0.00			
AMBULATORY SURGERY	11,814.00	3,976.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,208.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,228.60	2,446.00			
			TOTAL ANCILLARY	2,740,497.16	199,611.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,740,497.16	199,611.84

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

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

Run Date: 09/24/2013  
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KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2211272005018	09/16/11 - 09/16/11	10/03/11	0.00	36.20	0.00	0.00	0.00
TOTAL				0.00	36.20	0.00	0.00	0.00



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

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

Run Date: 09/24/2013  
Run Time: 16:03:25  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	92,431.98	ADJUSTMENTS	0.00
COVERED CHARGES	75,107.17	CONTRACTUAL ALLOW	24,211.45
NON-COVERD CHARGES	17,324.81	TOTAL MEDICAID LIAB	50,895.72
		LESS: COB	50,877.72
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 76

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

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,619.83	20.16	OTHER LAB	728.00	0.00
MED/SURG SUPPLY	2,640.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	15.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,516.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,833.00	7,081.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	868.00	FEE SCHEDULE LAB	16,016.00	4,586.00
EKG/ECG	1,890.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,251.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,707.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	702.00	142.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	998.00	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	21,720.00	1,305.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	810.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,926.73	1,549.65
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	979.00	1,758.00			
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	2,802.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	898.00	0.00			
			TOTAL ANCILLARY	75,107.17	17,324.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	75,107.17	17,324.81

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

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

Run Date: 09/24/2013  
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KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	182,549.58	ADJUSTMENTS	1,085.79
COVERED CHARGES	167,729.68	CONTRACTUAL ALLOW	150,388.29
NON-COVERD CHARGES	14,819.90	TOTAL MEDICAID LIAB	17,341.39
		LESS: COB	0.00
		LESS: COPAYMENT	462.04
		REIMBURSEMENT	16,879.35
		TOTAL NUMBER OF CLAIMS	310

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,558.43	94.50	OTHER LAB	924.00	0.00
MED/SURG SUPPLY	467.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,238.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,055.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,471.00	7,103.00
EKG/ECG	945.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,752.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	633.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	107,777.00	6,586.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,211.25	743.40
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	5,515.00	293.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	183.00	0.00			
			TOTAL ANCILLARY	167,729.68	14,819.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	167,729.68	14,819.90

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,543.32	ADJUSTMENTS	0.00
COVERED CHARGES	4,100.32	CONTRACTUAL ALLOW	1,616.94
NON-COVERD CHARGES	443.00	TOTAL MEDICAID LIAB	2,483.38
		LESS: COB	2,480.38
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	418.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	428.00	182.00
EKG/ECG	182.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,985.00	261.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36.20	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	4,100.32	443.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,100.32	443.00

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

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	339,351.20	ADJUSTMENTS	64,304.69
COVERED CHARGES	336,524.92	CONTRACTUAL ALLOW	267,083.10
NON-COVERD CHARGES	2,826.28	TOTAL MEDICAID LIAB	69,441.82
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	69,264.82

TOTAL NUMBER OF CLAIMS 14

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

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,237.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,340.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	896.00	0.00	OTHER THERAPEUTIC SVC	0.00	825.00
CT SCAN	4,514.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,375.00	173.00
EKG/ECG	378.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,444.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,418.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	760.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	684.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	540.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	223,211.56	1,255.28
RADIOLOGY THERAPEUTIC	29,106.00	573.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,620.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	336,524.92	2,826.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	336,524.92	2,826.28



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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER 000000822A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,535,256.09	ADJUSTMENTS	1,191,987.90
COVERED CHARGES	23,591,121.96	CONTRACTUAL ALLOW	15,233,396.40
NON-COVERD CHARGES	944,134.13	TOTAL MEDICAID LIAB	8,357,725.56
		LESS: COB	85,799.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,271,926.03

TOTAL NUMBER OF ADMISSIONS 966

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,201		0	2,512,605.00		507,337.00
ROUTINE NURSERY	307		0	253,959.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,508		0	2,766,564.00		507,337.00
SPECIAL CARE SERVICES						
CCU	424		0	761,885.00		0.00
ICU	1,679		0	2,499,786.00		0.00
NICU	48		0	71,980.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,151		0	3,333,651.00		0.00
TOTAL ACCOMODATIONS	5,659		0	6,100,215.00		507,337.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,245,003.97	50,535.82	OTHER LAB	114,898.00	0.00
MED/SURG SUPPLY	2,041,352.79	39,356.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,081,187.52	22,090.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	465,984.00	1,701.00	OTHER THERAPEUTIC SVC	0.00	910.00
CT SCAN	429,909.00	133,629.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	165,632.00	1,996.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	105,515.00	0.00	MRI SERVICES	253,005.00	0.00
IV THERAPY	243,997.00	9,529.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,873,508.00	36,400.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	151,356.00	0.00	REHAB THERAPY	3,608.00	0.00
RESPIRATORY SERVICES	1,227,145.00	1,450.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	404,039.00	6,998.00	AMBULANCE	0.00	0.00
GI SERVICES	2,580.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	366,187.00	249.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	138,038.00	1,674.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	151,450.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	123,342.00	2,258.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,278.00	266.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	287,027.00	15,728.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	115.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,887.68	0.00
LITHOTRIPSY	12,074.00	0.00	NO CC/INVALID REV CODE	0.00	8,337.00
OTHER IMAGING SERVICE	85,139.00	20,585.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	565,894.00	56,926.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	88,057.00	24,326.00			
AUDIOLOGY	10,450.00	0.00			
CARDIOLOGY	684,805.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	38,981.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	75,577.00	1,738.00			
			TOTAL ANCILLARY	17,490,906.96	436,797.13
			TOTAL ACCOMODATIONS	6,100,215.00	507,337.00
			TOTAL CHARGES	23,591,121.96	944,134.13

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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GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
32	2211223012578	07/29/11 - 08/05/11	08/15/11	0.00	1,917.00	0.00	0.00	0.00
615	2212044003747	01/30/12 - 02/03/12	02/20/12	0.00	1,860.00	0.00	0.00	0.00
615	2212108015977	02/13/12 - 03/05/12	04/23/12	0.00	1,860.00	0.00	0.00	0.00
615	2012128013832	01/30/12 - 02/02/12	05/14/12	0.00	2,700.00	0.00	0.00	0.00
TOTAL				0.00	8,337.00	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: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	811,322.77	ADJUSTMENTS	0.00
COVERED CHARGES	801,323.77	CONTRACTUAL ALLOW	144,139.38
NON-COVERD CHARGES	9,999.00	TOTAL MEDICAID LIAB	657,184.39
		LESS: COB	657,184.39
		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	89		0	79,252.00		3,934.00
ROUTINE NURSERY	2		0	1,658.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	91		0	80,910.00		3,934.00
SPECIAL CARE SERVICES						
CCU	19		0	34,411.00		0.00
ICU	51		0	85,648.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	70		0	120,059.00		0.00
TOTAL ACCOMODATIONS	161		0	200,969.00		3,934.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	235,308.84	0.00	OTHER LAB	924.00	0.00
MED/SURG SUPPLY	50,536.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	61,229.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,870.00	0.00	OTHER THERAPEUTIC SVC	0.00	69.00
CT SCAN	7,424.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,792.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,753.00	0.00	MRI SERVICES	5,580.00	0.00
IV THERAPY	4,817.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,027.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,648.00	0.00	REHAB THERAPY	224.00	0.00
RESPIRATORY SERVICES	60,809.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,948.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	860.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,808.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,780.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,067.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	453.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,996.00
OTHER IMAGING SERVICE	444.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,229.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	85.00	0.00			
CARDIOLOGY	19,632.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,464.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,642.00	0.00			
			TOTAL ANCILLARY	600,354.77	6,065.00
			TOTAL ACCOMODATIONS	200,969.00	3,934.00
			TOTAL CHARGES	801,323.77	9,999.00

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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GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
5996	2212185012381	03/20/12 - 04/02/12	07/09/12	0.00	5,996.00	0.00	46,829.71	0.00
TOTAL				0.00	5,996.00	0.00	46,829.71	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: 09/24/2013  
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GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,435,250.65	ADJUSTMENTS	1,000,354.58
COVERED CHARGES	11,330,403.60	CONTRACTUAL ALLOW	8,330,114.90
NON-COVERD CHARGES	1,104,847.05	TOTAL MEDICAID LIAB	3,000,288.70
		LESS: COB	1,986.26
		LESS: COPAYMENT	12,553.45
		REIMBURSEMENT	2,985,748.99
		ALL OTHER	2,456,520.07
		FEE SCHEDULE-LAB	261,331.83
		INJECTABLE DRUGS	267,897.09

TOTAL NUMBER OF CLAIMS 7,585



GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	644,339.11	13,259.87	OTHER LAB	151,726.00	0.00
MED/SURG SUPPLY	596,276.96	9,103.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	113.00	EDUCATION & TRAINING	250.00	0.00
RADIOLOGY-DIAGNOSTIC	506,077.00	18,495.00	OTHER THERAPEUTIC SVC	0.00	7,985.00
CT SCAN	854,722.00	36,694.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	70,523.00	31,382.00	FEE SCHEDULE LAB	1,160,140.23	222,131.55
EKG/ECG	93,067.00	1,016.00	MRI SERVICES	427,957.00	14,462.00
IV THERAPY	449,425.00	5,974.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	741,186.60	174,215.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	41,759.01	7,935.00	REHAB THERAPY	0.00	2,256.00
RESPIRATORY SERVICES	115,795.00	2,358.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	158,670.00	140.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,500,915.00	26,008.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	110,945.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,230,951.37	192,902.17
RADIOLOGY THERAPEUTIC	1,258,700.00	115,931.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,245.00	14,732.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,272.00	1,821.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,928.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,295.00	1,139.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	734.00	983.00
LITHOTRIPSY	24,148.00	0.00	NO CC/INVALID REV CODE	0.00	36.00
OTHER IMAGING SERVICE	504,686.00	22,428.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	116,356.00	465.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	88,957.00	37,909.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	183,885.00	135,801.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,072.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	260,328.32	5,243.68			
			TOTAL ANCILLARY	11,330,403.60	1,104,847.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,330,403.60	1,104,847.05

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: 09/24/2013  
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GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8561	5911204019013	05/06/11 - 05/06/11	08/01/11	0.00	19.00	0.00	0.00	0.00
8100	5912003001118	08/03/11 - 08/03/11	01/09/12	0.00	17.00	0.00	0.00	0.00
TOTAL				0.00	36.00	0.00	0.00	0.00

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

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	227,155.07	ADJUSTMENTS	0.00
COVERED CHARGES	191,161.22	CONTRACTUAL ALLOW	127,078.63
NON-COVERD CHARGES	35,993.85	TOTAL MEDICAID LIAB	64,082.59
		LESS: COB	63,923.40
		LESS: COPAYMENT	159.19
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 120

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

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,041.00	172.42	OTHER LAB	607.00	0.00
MED/SURG SUPPLY	6,423.90	204.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,356.00	193.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,731.00	1,950.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	889.00	267.00	FEE SCHEDULE LAB	16,468.00	5,142.00
EKG/ECG	1,270.00	0.00	MRI SERVICES	2,700.00	6,097.00
IV THERAPY	10,543.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,018.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	175.00	137.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,264.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,690.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	601.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,865.00	261.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,988.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,215.32	12,303.43
RADIOLOGY THERAPEUTIC	2,657.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	179.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,618.00	6,808.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,754.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	790.00	1,465.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,863.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,221.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,234.00	994.00			
			TOTAL ANCILLARY	191,161.22	35,993.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	191,161.22	35,993.85

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: 09/24/2013  
Run Time: 16:07:43  
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GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	602,837.81	ADJUSTMENTS	4,511.82
COVERED CHARGES	564,672.88	CONTRACTUAL ALLOW	521,029.76
NON-COVERD CHARGES	38,164.93	TOTAL MEDICAID LIAB	43,643.12
		LESS: COB	34.13
		LESS: COPAYMENT	1,533.18
		REIMBURSEMENT	42,075.81
		TOTAL NUMBER OF CLAIMS	781

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,423.14	1,553.96	OTHER LAB	2,059.00	0.00
MED/SURG SUPPLY	6,293.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,086.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,417.00	975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	85,151.00	13,752.60
EKG/ECG	4,181.00	127.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,745.00	366.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	316.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	162.00	650.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,178.00	173.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	295,479.00	10,476.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,921.24	8,193.37
RADIOLOGY THERAPEUTIC	12,858.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	138.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,745.00	1,510.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,296.00	388.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,401.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,823.00	0.00			
			TOTAL ANCILLARY	564,672.88	38,164.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	564,672.88	38,164.93

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: 09/24/2013  
Run Time: 16:07:57  
Page: 14

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,474.82	ADJUSTMENTS	0.00
COVERED CHARGES	6,540.10	CONTRACTUAL ALLOW	3,545.76
NON-COVERD CHARGES	2,934.72	TOTAL MEDICAID LIAB	2,994.34
		LESS: COB	2,964.34
		LESS: COPAYMENT	30.00
		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: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203.30	75.32	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,391.00	801.00	FEE SCHEDULE LAB	601.00	256.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	353.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,345.00	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	325.80	72.40
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	293.00	755.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,540.10	2,934.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,540.10	2,934.72



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: 09/24/2013  
Run Time: 16:07:59  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,694,922.42	ADJUSTMENTS	207,265.02
COVERED CHARGES	1,615,661.61	CONTRACTUAL ALLOW	1,290,435.75
NON-COVERD CHARGES	79,260.81	TOTAL MEDICAID LIAB	325,225.86
		LESS: COB	0.00
		LESS: COPAYMENT	960.18
		REIMBURSEMENT	324,265.68

TOTAL NUMBER OF CLAIMS 63

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

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,429.82	583.97	OTHER LAB	420.00	0.00
MED/SURG SUPPLY	170,817.49	5,497.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,647.00	3,377.00	OTHER THERAPEUTIC SVC	0.00	2,129.00
CT SCAN	6,773.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,228.00	3,041.00	FEE SCHEDULE LAB	17,263.00	7,192.00
EKG/ECG	381.00	0.00	MRI SERVICES	1,690.00	0.00
IV THERAPY	238,720.00	943.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	172,374.00	13,092.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,486.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,676.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,461.00	1,065.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,280.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	556,057.30	28,484.76
RADIOLOGY THERAPEUTIC	203,412.00	3,069.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,206.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,390.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	455.00	462.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,126.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,575.00	8,118.00			
			TOTAL ANCILLARY	1,615,661.61	79,260.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,615,661.61	79,260.81

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

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

Run Date: 09/24/2013  
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Page: 18

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000833A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,624,945.80	ADJUSTMENTS	331,632.08
COVERED CHARGES	12,921,853.00	CONTRACTUAL ALLOW	9,117,203.67
NON-COVERD CHARGES	703,092.80	TOTAL MEDICAID LIAB	3,804,649.33
		LESS: COB	57,343.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,747,305.92

TOTAL NUMBER OF ADMISSIONS 567

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,107		0	558,281.65		46,582.46
ROUTINE NURSERY	193		0	93,587.10		2,236.62
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,470.70
TOTAL ROUTINE	1,300		0	651,868.75		50,289.78
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	757		0	1,098,794.54		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	757		0	1,098,794.54		0.00
TOTAL ACCOMODATIONS	2,057		0	1,750,663.29		50,289.78

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	535,557.82	3,565.76	OTHER LAB	39,464.85	0.00
MED/SURG SUPPLY	415,486.52	2,242.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,933,588.02	4,886.76	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	279,006.71	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	335,496.57	588,793.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	99,736.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	226,664.56	0.00	MRI SERVICES	218,220.51	0.00
IV THERAPY	105,688.75	1,504.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	944,747.16	1,888.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	189,202.26	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	866,082.82	849.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	205,049.78	0.00	AMBULANCE	0.00	0.00
GI SERVICES	101,815.74	2,692.13	CAST ROOM	0.00	0.00
EMERGENCY ROOM	444,541.07	744.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	63,550.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	71,317.18	0.00	INJECTABLE DRUGS	2,873,470.60	692.71
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	6,291.95	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	51.08	200.35	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	539,124.47	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,906.26
OTHER IMAGING SERVICE	90,100.74	20,102.67			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,335.34	2,178.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	150,241.49	18,555.67			
AUDIOLOGY	9,650.41	0.00			
CARDIOLOGY	383,633.11	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,983.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,089.59	0.00			
			TOTAL ANCILLARY	11,171,189.71	652,803.02
			TOTAL ACCOMODATIONS	1,750,663.29	50,289.78
			TOTAL CHARGES	12,921,853.00	703,092.80

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

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

Run Date: 09/24/2013  
Run Time: 16:08:12  
Page: 3

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

PART III NO COST CENTER OR 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	2012136052538	05/06/12 - 05/07/12	05/21/12	0.00	1,953.13	0.00	0.00	0.00
615	2012177034446	06/13/12 - 06/16/12	07/02/12	0.00	1,953.13	0.00	0.00	0.00
TOTAL				0.00	3,906.26	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: 09/24/2013  
 Run Time: 16:08:36  
 Page: 4

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	172,065.43	ADJUSTMENTS	0.00
COVERED CHARGES	171,645.33	CONTRACTUAL ALLOW	79,988.92
NON-COVERD CHARGES	420.10	TOTAL MEDICAID LIAB	91,656.41
		LESS: COB	91,656.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14		0	7,097.57		420.10
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14		0	7,097.57		420.10
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	11		0	12,085.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	12,085.00		0.00
TOTAL ACCOMODATIONS	25		0	19,182.57		420.10

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,844.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,672.31	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,067.46	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,509.36	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,010.62	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,560.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,829.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,277.56	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,185.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,707.24	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,762.71	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,129.06	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,946.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	817.37	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,369.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	586.83	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,783.94	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.	403.92	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	152,462.76	0.00
			TOTAL ACCOMODATIONS	19,182.57	420.10
			TOTAL CHARGES	171,645.33	420.10



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: 09/24/2013  
Run Time: 16:08:37  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,995,277.50	ADJUSTMENTS	182,423.84
COVERED CHARGES	11,126,736.51	CONTRACTUAL ALLOW	8,886,123.78
NON-COVERD CHARGES	868,540.99	TOTAL MEDICAID LIAB	2,240,612.73
		LESS: COB	9,367.01
		LESS: COPAYMENT	4,341.00
		REIMBURSEMENT	2,226,904.72
		ALL OTHER	2,054,776.21
		FEE SCHEDULE-LAB	168,640.77
		INJECTABLE DRUGS	3,487.74
		TOTAL NUMBER OF CLAIMS	4,720

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
 000000833A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177,227.11	1,780.29	OTHER LAB	45,249.34	0.00
MED/SURG SUPPLY	328,413.21	1,556.51	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	294.18	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	654,739.70	13,365.12	OTHER THERAPEUTIC SVC	0.00	18,328.42
CT SCAN	2,093,442.96	56,811.79	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,805.52	11,946.71	FEE SCHEDULE LAB	1,797,209.76	266,234.67
EKG/ECG	140,131.13	8,504.43	MRI SERVICES	656,871.55	11,128.72
IV THERAPY	326,625.78	47,083.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	848,272.90	70,677.42	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,033.54	522.21	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,824.91	69,150.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	192,762.02	4,353.49	AMBULANCE	0.00	0.00
GI SERVICES	132,155.18	8,217.28	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,212,424.51	13,418.12	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,886.70	711.10	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,438.64	89,598.92
RADIOLOGY THERAPEUTIC	4,015.38	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,889.89	310.26	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	274.18	1,233.81	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41,537.88	2,876.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,923.72	42,357.77
LITHOTRIPSY	41,423.90	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	393,451.66	59,868.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,423.52	6,039.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	301,617.10	48,521.17			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	151,157.88	11,560.68			
AMBULATORY SURGERY	0.00	1,152.37			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	178,567.07	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	117,939.87	937.60			
			TOTAL ANCILLARY	11,126,736.51	868,540.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,126,736.51	868,540.99

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	352,829.09	ADJUSTMENTS	0.00
COVERED CHARGES	243,686.12	CONTRACTUAL ALLOW	115,353.13
NON-COVERD CHARGES	109,142.97	TOTAL MEDICAID LIAB	128,332.99
		LESS: COB	128,272.99
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 126

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,223.36	4,524.35	OTHER LAB	570.84	0.00
MED/SURG SUPPLY	19,246.52	1,530.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	42.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,266.47	449.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,943.61	44,588.06	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	59,372.66	7,231.95
EKG/ECG	3,350.23	0.00	MRI SERVICES	3,562.31	9,304.42
IV THERAPY	11,091.92	550.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,483.19	5,748.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	623.28	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	534.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,675.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	8,305.37	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,925.03	1,482.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,339.33	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	4,664.79
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	137.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,820.51	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	279.33	902.59
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,137.95	6,700.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,817.92	1,419.61			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,119.72	11,560.68			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	843.29	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,458.20	0.00			
			TOTAL ANCILLARY	243,686.12	109,142.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	243,686.12	109,142.97

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: 09/24/2013  
Run Time: 16:10:58  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	941,574.21	ADJUSTMENTS	594.34
COVERED CHARGES	910,617.69	CONTRACTUAL ALLOW	857,250.93
NON-COVERD CHARGES	30,956.52	TOTAL MEDICAID LIAB	53,366.76
		LESS: COB	0.00
		LESS: COPAYMENT	1,590.00
		REIMBURSEMENT	51,776.76
		TOTAL NUMBER OF CLAIMS	954

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

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

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,490.91	211.15	OTHER LAB	2,842.45	0.00
MED/SURG SUPPLY	3,981.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,304.84	1,922.84	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,377.77	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	149,621.17	9,469.49
EKG/ECG	9,199.87	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	44,201.37	3,405.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,243.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	571,836.74	2,386.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	2,403.29
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	1,048.00	204.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,749.40	10,953.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,720.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	910,617.69	30,956.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	910,617.69	30,956.52

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

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

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,361.45	ADJUSTMENTS	0.00
COVERED CHARGES	21,290.24	CONTRACTUAL ALLOW	12,862.87
NON-COVERD CHARGES	2,071.21	TOTAL MEDICAID LIAB	8,427.37
		LESS: COB	8,415.37
		LESS: COPAYMENT	12.00
		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

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,140.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,705.78	979.20
EKG/ECG	515.42	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,388.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,498.58	187.52	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	61.80
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	842.69			
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	21,290.24	2,071.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,290.24	2,071.21



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: 09/24/2013  
Run Time: 16:11:15  
Page: 14

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	645,591.50	ADJUSTMENTS	25,897.15
COVERED CHARGES	599,995.77	CONTRACTUAL ALLOW	486,021.91
NON-COVERD CHARGES	45,595.73	TOTAL MEDICAID LIAB	113,973.86
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	113,877.86
		TOTAL NUMBER OF CLAIMS	22

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,967.78	0.00	OTHER LAB	1,782.50	0.00
MED/SURG SUPPLY	32,200.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,578.67	2,160.12	OTHER THERAPEUTIC SVC	0.00	1,239.47
CT SCAN	73,088.38	10,703.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,688.04	3,648.17
EKG/ECG	3,092.52	515.42	MRI SERVICES	2,751.31	4,652.21
IV THERAPY	6,441.67	4,688.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	106,979.95	1,461.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,166.11	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,868.17	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,391.10	372.34	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,805.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,758.41	4,663.00
RADIOLOGY THERAPEUTIC	73,506.90	1,696.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	42.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,790.43	4,932.67
LITHOTRIPSY	20,711.95	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,192.46	844.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	29,089.60	3,976.39			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	69,210.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,933.53	0.00			
			TOTAL ANCILLARY	599,995.77	45,595.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	599,995.77	45,595.73

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

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

Run Date: 09/24/2013  
Run Time: 16:11:17  
Page: 16

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

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 16:11:26  
 Page: 1

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,157,164.15	ADJUSTMENTS	111,749.24
COVERED CHARGES	1,148,117.15	CONTRACTUAL ALLOW	538,543.14
NON-COVERD CHARGES	9,047.00	TOTAL MEDICAID LIAB	609,574.01
		LESS: COB	1,592.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	607,981.95

TOTAL NUMBER OF ADMISSIONS 218

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	228		0	123,348.00		3,361.00
ROUTINE NURSERY	139		0	61,299.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	367		0	184,647.00		3,361.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	15		0	19,455.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	19,455.00		0.00
TOTAL ACCOMODATIONS	382		0	204,102.00		3,361.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL  
 1155 5TH ST SE  
 CAIRO,GA 39828-3142

PROVIDER NUMBER  
 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	161,025.40	0.00	OTHER LAB	2,296.00	0.00
MED/SURG SUPPLY	80,684.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	184,233.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,814.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	59,997.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,732.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,617.00	0.00	MRI SERVICES	5,018.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	110,636.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	182,106.00	3,353.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,350.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,248.00	281.00	AMBULANCE	0.00	0.00
GI SERVICES	3,741.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,333.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,286.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,886.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	9,990.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	327.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,515.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,365.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,477.00	2,052.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	547.00	0.00			
AUDIOLOGY	11,495.00	0.00			
CARDIOLOGY	6,659.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,637.00	0.00			
			TOTAL ANCILLARY	944,015.15	5,686.00
			TOTAL ACCOMODATIONS	204,102.00	3,361.00
			TOTAL CHARGES	1,148,117.15	9,047.00

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

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

Run Date: 09/24/2013  
Run Time: 16:11:32  
Page: 3

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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 16:11:32  
Page: 4

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,800,547.66	ADJUSTMENTS	78,037.92
COVERED CHARGES	1,614,753.75	CONTRACTUAL ALLOW	1,197,702.73
NON-COVERD CHARGES	185,793.91	TOTAL MEDICAID LIAB	417,051.02
		LESS: COB	826.11
		LESS: COPAYMENT	2,604.00
		REIMBURSEMENT	413,620.91
		ALL OTHER	364,260.79
		FEE SCHEDULE-LAB	46,384.22
		INJECTABLE DRUGS	2,975.90

TOTAL NUMBER OF CLAIMS 1,821

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,590.00	3,509.00	OTHER LAB	12,253.00	0.00
MED/SURG SUPPLY	63,704.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	103,962.00	1,328.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	209,967.00	14,853.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,247.00	17,973.00	FEE SCHEDULE LAB	361,063.76	67,627.30
EKG/ECG	10,400.00	538.00	MRI SERVICES	20,643.00	0.00
IV THERAPY	72,396.00	15,034.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	150,112.39	16,618.61	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,703.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,958.00	1,753.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,060.00	281.00	AMBULANCE	0.00	0.00
GI SERVICES	66,702.00	4,474.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	265,118.00	1,305.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,545.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,817.60	31,096.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,462.00	7,257.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,550.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,015.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	56,731.00	316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,946.00	1,635.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,486.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,322.00	196.00			
			TOTAL ANCILLARY	1,614,753.75	185,793.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,614,753.75	185,793.91



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: 09/24/2013  
Run Time: 16:12:04  
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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,750.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,199.00	CONTRACTUAL ALLOW	1,846.87
NON-COVERD CHARGES	551.00	TOTAL MEDICAID LIAB	2,352.13
		LESS: COB	2,349.13
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	79.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,088.00	15.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	591.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	31.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	387.00	189.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	469.00	316.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,199.00	551.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,199.00	551.00

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

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

Run Date: 09/24/2013  
Run Time: 16:12:05  
Page: 8

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,126.00	ADJUSTMENTS	1,073.79
COVERED CHARGES	80,490.00	CONTRACTUAL ALLOW	70,595.56
NON-COVERD CHARGES	2,636.00	TOTAL MEDICAID LIAB	9,894.44
		LESS: COB	0.00
		LESS: COPAYMENT	252.01
		REIMBURSEMENT	9,642.43
		TOTAL NUMBER OF CLAIMS	177

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	791.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	840.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,075.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,292.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,051.00	1,744.00
EKG/ECG	218.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,538.00	756.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,990.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,799.00	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	1,896.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	80,490.00	2,636.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,490.00	2,636.00

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	621.00	ADJUSTMENTS	0.00
COVERED CHARGES	621.00	CONTRACTUAL ALLOW	393.02
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	227.98
		LESS: COB	227.98
		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: 09/24/2013  
 Run Time: 16:12:08  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.00	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	176.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	84.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	6.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	621.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	621.00	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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,021.00	ADJUSTMENTS	4,853.66
COVERED CHARGES	18,711.00	CONTRACTUAL ALLOW	13,848.34
NON-COVERD CHARGES	310.00	TOTAL MEDICAID LIAB	4,862.66
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	4,853.66

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	595.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,959.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	158.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,287.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	502.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	498.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	272.00	310.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,440.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,711.00	310.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,711.00	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: 09/24/2013  
Run Time: 16:12:09  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL  
 80 JESSE HILL JR DR SE  
 ATLANTA,GA 30303-3031

PROVIDER NUMBER 000000855A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	357,532,825.55	ADJUSTMENTS	55,846,321.80
COVERED CHARGES	340,724,995.16	CONTRACTUAL ALLOW	223,564,014.72
NON-COVERD CHARGES	16,807,830.39	TOTAL MEDICAID LIAB	117,160,980.44
		LESS: COB	373,982.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	116,786,998.43

TOTAL NUMBER OF ADMISSIONS 7,753

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	31,917		0	39,176,304.00		3,190,960.00
ROUTINE NURSERY	3,178		3	3,683,646.00		114,540.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		317,321.94
TOTAL ROUTINE	35,095		3	42,859,950.00		3,622,821.94
SPECIAL CARE SERVICES						
CCU	3,242		0	10,253,232.00		64,262.00
ICU	11,772		0	42,185,719.00		452,574.00
NICU	2,912		0	13,008,438.50		0.00
PED ICU	2		0	5,344.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	1		0	2,672.00		0.00
BURN UNIT	448		0	2,998,440.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	18,377		0	68,453,845.50		516,836.00
TOTAL ACCOMODATIONS	53,472		3	111,313,795.50		4,139,657.94

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,708,746.58	457,024.01	OTHER LAB	735,016.00	3,516.00
MED/SURG SUPPLY	14,351,964.10	2,160,955.43	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,048,706.70	723,030.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,159,082.50	49,365.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,962,611.00	3,300,730.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,770,809.00	147,994.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,171,155.60	5,594.00	MRI SERVICES	3,016,126.00	12,970.00
IV THERAPY	321,733.00	23,931.00	PROFESSIONAL FEES	0.00	1,129.00
OPERATING ROOM	57,060,651.50	1,056,306.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,709,778.00	9,573.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,066,423.00	725,088.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,309,559.00	83,426.00	AMBULANCE	0.00	0.00
GI SERVICES	703,613.00	29,274.00	CAST ROOM	2,247.00	1,591.00
EMERGENCY ROOM	9,388,680.00	181,136.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,692,928.00	17,779.00	DRUG-SPECIFIC/HOME IV	0.00	413.61
LABORATORY PATHOLOGIC	828,802.00	8,668.00	INJECTABLE DRUGS	14,826,799.45	238,805.93
RADIOLOGY THERAPEUTIC	869,541.00	13,907.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	824,019.00	21,905.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,408,477.00	25,610.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,252,669.00	62,873.00	PATIENT CONVENIENCE	0.00	16,884.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,321.00	212,827.00	TRAUMA RESPONSE	0.00	736,974.00
PSYCHIATRIC SERVICES	11,223.00	0.00	IMPL DEV CHARGE PATIENTS	3,930,805.43	1,127,413.87
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	28,733.00
OTHER IMAGING SERVICE	1,043,230.00	430,471.00			
BLOOD	15,050.00	0.00			
BLOOD STORAGE & PRO.	6,123,215.72	349,762.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	613,892.00	370,682.00			
AUDIOLOGY	715,163.00	0.00			
CARDIOLOGY	2,763,436.00	23,897.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,203,062.00	4,402.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	798,664.08	3,532.00			
			TOTAL ANCILLARY	229,411,199.66	12,668,172.45
			TOTAL ACCOMODATIONS	111,313,795.50	4,139,657.94
			TOTAL CHARGES	340,724,995.16	16,807,830.39

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: 09/24/2013  
Run Time: 16:12:16  
Page: 3

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

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2	2212027018734	01/04/12 - 01/06/12	01/30/12	0.00	98.00	0.00	0.00	0.00
575	2213234019737	09/16/12 - 10/05/12	08/26/13	0.00	28,635.00	0.00	0.00	0.00
TOTAL				0.00	28,733.00	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: 09/24/2013  
 Run Time: 16:16:36  
 Page: 4

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,654,869.07	ADJUSTMENTS	0.00
COVERED CHARGES	1,647,436.07	CONTRACTUAL ALLOW	840,149.96
NON-COVERD CHARGES	7,433.00	TOTAL MEDICAID LIAB	807,286.11
		LESS: COB	807,286.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	49		0	67,417.00		3,763.00
ROUTINE NURSERY	0		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	67,417.00		3,763.00
SPECIAL CARE SERVICES						
CCU	7		0	31,192.00		0.00
ICU	33		0	129,208.00		0.00
NICU	42		0	187,152.00		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	82		0	347,552.00		0.00
TOTAL ACCOMODATIONS	131		0	414,969.00		3,763.00

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	207,192.71	0.00	OTHER LAB	1,302.00	0.00
MED/SURG SUPPLY	142,091.94	1,203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	133,431.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,803.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,726.00	2,159.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,895.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,082.00	0.00	MRI SERVICES	10,925.00	0.00
IV THERAPY	2,428.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	118,882.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,910.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	175,837.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,742.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,449.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,542.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	852.00	0.00	INJECTABLE DRUGS	128,078.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,358.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,361.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,561.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	308.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	171.00	0.00	IMPL DEV CHARGE PATIENTS	45,483.85	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,382.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,365.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,064.00	0.00			
CARDIOLOGY	6,543.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	398.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	611.00	0.00			
			TOTAL ANCILLARY	1,232,467.07	3,670.00
			TOTAL ACCOMODATIONS	414,969.00	3,763.00
			TOTAL CHARGES	1,647,436.07	7,433.00

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: 09/24/2013  
Run Time: 16:16:56  
Page: 6

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,619,201.59	ADJUSTMENTS	2,251,572.00
COVERED CHARGES	66,256,516.61	CONTRACTUAL ALLOW	45,545,014.41
NON-COVERD CHARGES	9,362,684.98	TOTAL MEDICAID LIAB	20,711,502.20
		LESS: COB	17,536.42
		LESS: COPAYMENT	146,845.22
		REIMBURSEMENT	20,547,120.56
		ALL OTHER	17,241,542.79
		FEE SCHEDULE-LAB	1,930,361.62
		INJECTABLE DRUGS	1,375,216.15

TOTAL NUMBER OF CLAIMS 72,024

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	287,648.27	36,880.72	OTHER LAB	729,203.00	33,435.00
MED/SURG SUPPLY	745,521.74	85,004.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	446.00	EDUCATION & TRAINING	0.00	71,718.00
RADIOLOGY-DIAGNOSTIC	2,287,812.00	97,851.50	OTHER THERAPEUTIC SVC	0.00	1,414.50
CT SCAN	3,761,326.00	149,794.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	209,117.00	36,543.00	FEE SCHEDULE LAB	15,584,049.10	4,470,183.10
EKG/ECG	725,446.00	70,520.00	MRI SERVICES	1,623,092.00	64,842.00
IV THERAPY	1,092,374.00	123,130.47	PROFESSIONAL FEES	0.00	552.00
OPERATING ROOM	3,245,592.73	1,099,996.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	366,137.00	15,425.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	790,443.00	119,495.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	238,839.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	717,810.00	128,656.00	CAST ROOM	4,093.00	0.00
EMERGENCY ROOM	13,971,293.00	164,241.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,934.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,626,010.47	764,740.02
RADIOLOGY THERAPEUTIC	2,004,480.00	13,213.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	44,436.00	21,182.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	34,767.00	18,492.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	52,260.00	PATIENT CONVENIENCE	0.00	775.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,965,082.00	270,115.56	TRAUMA RESPONSE	0.00	176,206.00
PSYCHIATRIC SERVICES	797,154.00	209,138.00	IMPL DEV CHARGE PATIENTS	35,747.00	60,259.71
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,066,762.50	94,167.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	563,063.00	4,059.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,002,326.00	784,804.00			
AUDIOLOGY	52,441.00	10,086.00			
CARDIOLOGY	1,044,734.00	105,065.00			
AMBULATORY SURGERY	0.00	3,696.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	71,244.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	490,538.80	2,850.00			
			TOTAL ANCILLARY	66,256,516.61	9,361,236.98
			TOTAL ACCOMODATIONS	0.00	1,448.00
			TOTAL CHARGES	66,256,516.61	9,362,684.98



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

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

Run Date: 09/24/2013  
Run Time: 16:30:08  
Page: 8

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	121,077.52	ADJUSTMENTS	0.00
COVERED CHARGES	81,372.10	CONTRACTUAL ALLOW	51,434.95
NON-COVERD CHARGES	39,705.42	TOTAL MEDICAID LIAB	29,937.15
		LESS: COB	29,809.43
		LESS: COPAYMENT	127.72
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 131

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	314.19	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,476.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,596.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,591.00	12,692.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	446.00	0.00	FEE SCHEDULE LAB	22,921.00	5,278.00
EKG/ECG	616.00	308.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,838.00	1,740.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	642.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,635.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,808.00	4,328.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,574.00	1,153.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,460.91	638.42
RADIOLOGY THERAPEUTIC	2,328.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	823.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,037.00	1,152.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,131.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	756.00	8,513.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,292.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,772.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,914.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	304.00	0.00			
			TOTAL ANCILLARY	81,372.10	39,705.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,372.10	39,705.42

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

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

Run Date: 09/24/2013  
Run Time: 16:30:29  
Page: 10

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,424,120.81	ADJUSTMENTS	4,629.71
COVERED CHARGES	2,294,452.71	CONTRACTUAL ALLOW	2,182,181.15
NON-COVERD CHARGES	129,668.10	TOTAL MEDICAID LIAB	112,271.56
		LESS: COB	0.00
		LESS: COPAYMENT	5,760.38
		REIMBURSEMENT	106,511.18
		TOTAL NUMBER OF CLAIMS	2,008

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,849.84	1,466.58	OTHER LAB	6,408.00	0.00
MED/SURG SUPPLY	9,839.96	3,143.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,259.00	3,195.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,666.00	1,160.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	707.00	FEE SCHEDULE LAB	293,020.00	74,367.80
EKG/ECG	29,418.00	1,558.00	MRI SERVICES	15,999.00	0.00
IV THERAPY	46,772.00	14,964.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,921.00	3,788.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,485.00	263.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,969.00	884.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,936.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,574,249.00	9,100.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,231.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,502.91	11,589.72
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	599.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,263.00	539.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	458.00	IMPL DEV CHARGE PATIENTS	127.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,871.00	621.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,466.00	1,265.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	874.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,326.00	0.00			
			TOTAL ANCILLARY	2,294,452.71	129,668.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,294,452.71	129,668.10



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

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

Run Date: 09/24/2013  
 Run Time: 16:31:02  
 Page: 13

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,240.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,281.00	993.00
EKG/ECG	542.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	277.00	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	16,102.00	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	339.22	17.50
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	112.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
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	24,487.06	1,010.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,487.06	1,010.50

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

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

Run Date: 09/24/2013  
Run Time: 16:31:19  
Page: 14

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,478,163.70	ADJUSTMENTS	1,316,269.92
COVERED CHARGES	15,602,111.84	CONTRACTUAL ALLOW	11,898,240.32
NON-COVERD CHARGES	876,051.86	TOTAL MEDICAID LIAB	3,703,871.52
		LESS: COB	0.01
		LESS: COPAYMENT	5,271.19
		REIMBURSEMENT	3,698,600.32

TOTAL NUMBER OF CLAIMS 574

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,564.66	14,003.08	OTHER LAB	0.00	333.00
MED/SURG SUPPLY	314,089.16	27,681.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209,625.00	98,585.00	OTHER THERAPEUTIC SVC	0.00	2,009.00
CT SCAN	5,108.00	1,160.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	484.00	4,096.00	FEE SCHEDULE LAB	201,821.00	27,826.90
EKG/ECG	1,232.00	234.00	MRI SERVICES	0.00	0.00
IV THERAPY	256,264.00	402.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,251,042.10	209,007.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	349.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,303.00	1,717.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,254,963.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,895.00	580.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	358,763.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,625,288.65	140,797.26
RADIOLOGY THERAPEUTIC	2,970,606.00	60,097.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	874.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,995.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,508.00	1,389.00	TRAUMA RESPONSE	0.00	9,274.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	677,316.27	241,339.04
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,884.00	445.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72,432.00	1,321.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,550.00	5,500.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	206,984.00	24,385.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,040.00	0.00			
			TOTAL ANCILLARY	15,602,111.84	876,051.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,602,111.84	876,051.86



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

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

Run Date: 09/24/2013  
Run Time: 16:31:51  
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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000866A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,036,009.60	ADJUSTMENTS	1,345,585.26
COVERED CHARGES	31,442,045.30	CONTRACTUAL ALLOW	25,279,410.09
NON-COVERD CHARGES	593,964.30	TOTAL MEDICAID LIAB	6,162,635.21
		LESS: COB	63,820.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,098,815.01

TOTAL NUMBER OF ADMISSIONS 823

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,800		157	2,804,310.00		372,448.32
ROUTINE NURSERY	171		0	114,659.70		1,479.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,971		157	2,918,969.70		373,927.32
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	580		3	1,097,201.70		7,580.00
NICU	15		0	27,074.48		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	595		3	1,124,276.18		7,580.00
TOTAL ACCOMODATIONS	3,566		160	4,043,245.88		381,507.32

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000866A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,448,976.56	41,307.87	OTHER LAB	126,644.30	0.00
MED/SURG SUPPLY	3,679,702.29	43,834.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,965,318.21	19,193.61	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	563,267.18	485.00	OTHER THERAPEUTIC SVC	171.38	171.38
CT SCAN	1,395,365.73	12,043.24	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	127,903.67	19,314.80	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	266,345.44	0.00	MRI SERVICES	378,094.03	0.00
IV THERAPY	1,910.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,113,692.27	3,417.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	264,383.41	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,972,350.85	10,147.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	464,620.09	0.00	AMBULANCE	0.00	6,503.50
GI SERVICES	103,260.46	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,265,155.67	2,309.34	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	157,780.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	82,274.14	0.00	INJECTABLE DRUGS	23,989.72	0.00
RADIOLOGY THERAPEUTIC	36,465.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,795.26	2,826.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	30,172.34	3,836.98	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	292,236.15	3,466.62	PATIENT CONVENIENCE	0.00	125.93
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,764.46	199.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	463,667.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	97,390.46	16,260.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	344,491.06	26,135.27			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	162,120.54	127.63			
AUDIOLOGY	15,426.93	0.00			
CARDIOLOGY	1,228,344.81	751.06			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,381.09	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	259,337.07	0.00			
			TOTAL ANCILLARY	27,398,799.42	212,456.98
			TOTAL ACCOMODATIONS	4,043,245.88	381,507.32
			TOTAL CHARGES	31,442,045.30	593,964.30

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000866A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,818.80	ADJUSTMENTS	0.00
COVERED CHARGES	100,639.28	CONTRACTUAL ALLOW	40,285.81
NON-COVERD CHARGES	5,179.52	TOTAL MEDICAID LIAB	60,353.47
		LESS: COB	60,353.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	9,207.00		464.57
ROUTINE NURSERY	2		0	1,300.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	10,507.00		464.57
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	13		0	23,465.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	23,465.00		0.00
TOTAL ACCOMODATIONS	24		0	33,972.00		464.57

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000866A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,345.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,600.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,630.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,146.23	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,272.86	4,714.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	381.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	420.56	0.00	MRI SERVICES	4,211.73	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,748.81	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	173.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,179.49	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,071.49	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,452.47	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,437.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	930.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	330.61	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	264.98	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	374.11	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	695.27	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	66,667.28	4,714.95
			TOTAL ACCOMODATIONS	33,972.00	464.57
			TOTAL CHARGES	100,639.28	5,179.52

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: 09/24/2013  
Run Time: 16:33:22  
Page: 5

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

PROVIDER NUMBER  
000000866A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,553,500.58	ADJUSTMENTS	1,474,626.56
COVERED CHARGES	21,693,641.94	CONTRACTUAL ALLOW	17,636,788.47
NON-COVERD CHARGES	2,859,858.64	TOTAL MEDICAID LIAB	4,056,853.47
		LESS: COB	6,100.30
		LESS: COPAYMENT	5,817.00
		REIMBURSEMENT	4,044,936.17
		ALL OTHER	3,648,956.80
		FEE SCHEDULE-LAB	288,585.94
		INJECTABLE DRUGS	107,393.43
		TOTAL NUMBER OF CLAIMS	6,969

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

PROVIDER NUMBER  
 000000866A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	761,201.57	30,073.00	OTHER LAB	150,072.12	2,484.50
MED/SURG SUPPLY	1,403,380.38	60,729.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,300,485.21	19,871.63	OTHER THERAPEUTIC SVC	0.00	171.38
CT SCAN	2,749,953.98	556,478.27	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,544.56	14,345.31	FEE SCHEDULE LAB	3,730,125.08	709,798.74
EKG/ECG	481,328.21	18,006.88	MRI SERVICES	298,032.90	58,411.11
IV THERAPY	479,214.63	83,078.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	782,082.39	130,983.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182,613.92	38,576.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	432,551.78	0.00	AMBULANCE	0.00	0.00
GI SERVICES	167,981.94	25,886.90	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,603,530.22	110,423.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	106,243.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,513.60
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,579,447.60	542,599.78
RADIOLOGY THERAPEUTIC	101,710.85	222.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,085.45	12,177.83	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,976.93	5,219.42	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,733.31	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	177,141.18	25,058.67	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,950.14	115,739.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	518,353.61	67,569.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	74,572.62	24,000.81			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	296,496.13	5,644.80			
AUDIOLOGY	197.11	197.11			
CARDIOLOGY	427,029.06	126,914.65			
AMBULATORY SURGERY	11,983.20	4,585.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	515,455.96	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	324,899.97	66,363.04			
			TOTAL ANCILLARY	21,693,641.94	2,859,858.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,693,641.94	2,859,858.64

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: 09/24/2013  
Run Time: 16:36:02  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000866A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	197,595.30	ADJUSTMENTS	0.00
COVERED CHARGES	156,931.59	CONTRACTUAL ALLOW	95,460.42
NON-COVERD CHARGES	40,663.71	TOTAL MEDICAID LIAB	61,471.17
		LESS: COB	61,420.17
		LESS: COPAYMENT	51.00
		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

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

PROVIDER NUMBER  
 000000866A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,025.97	5.27	OTHER LAB	2,158.84	0.00
MED/SURG SUPPLY	11,321.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,381.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,682.62	24,480.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,335.51	2,525.12
EKG/ECG	2,187.68	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,637.43	953.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,502.42	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,389.78	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,136.87	2,538.03
RADIOLOGY THERAPEUTIC	4,087.33	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,435.12	853.13	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,077.65	8,843.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,237.74	464.33			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,638.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	694.95	0.00			
			TOTAL ANCILLARY	156,931.59	40,663.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	156,931.59	40,663.71

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: 09/24/2013  
Run Time: 16:36:06  
Page: 9

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

PROVIDER NUMBER  
000000866A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,852,935.09	ADJUSTMENTS	8,828.01
COVERED CHARGES	1,716,107.35	CONTRACTUAL ALLOW	1,650,489.75
NON-COVERD CHARGES	136,827.74	TOTAL MEDICAID LIAB	65,617.60
		LESS: COB	0.00
		LESS: COPAYMENT	2,313.17
		REIMBURSEMENT	63,304.43
		TOTAL NUMBER OF CLAIMS	1,173

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000866A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,789.92	524.76	OTHER LAB	10,185.50	0.00
MED/SURG SUPPLY	52,408.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132,822.51	787.71	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	107,866.60	59,085.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	253,261.87	38,074.99
EKG/ECG	33,864.68	463.00	MRI SERVICES	3,763.21	0.00
IV THERAPY	57,191.15	9,051.54	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,217.41	1,111.87	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	886,452.91	916.77	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105,462.52	20,042.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	398.68	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,570.65	6,077.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,822.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,428.00	293.00			
			TOTAL ANCILLARY	1,716,107.35	136,827.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,716,107.35	136,827.74

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

Run Date: 09/24/2013  
Run Time: 16:36:27  
Page: 11

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

PROVIDER NUMBER  
000000866A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,374.85	ADJUSTMENTS	0.00
COVERED CHARGES	20,960.17	CONTRACTUAL ALLOW	16,153.60
NON-COVERD CHARGES	1,414.68	TOTAL MEDICAID LIAB	4,806.57
		LESS: COB	4,785.57
		LESS: COPAYMENT	21.00
		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: 09/24/2013  
 Run Time: 16:36:27  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000866A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	259.53	293.53	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	968.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,598.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,647.72	28.72
EKG/ECG	883.56	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	965.42	651.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,519.52	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	1,295.50	441.43
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,822.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,960.17	1,414.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,960.17	1,414.68

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

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

Run Date: 09/24/2013  
Run Time: 16:36:29  
Page: 13

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

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

PROVIDER NUMBER  
000000866A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,609,807.13	ADJUSTMENTS	66,103.99
COVERED CHARGES	1,373,696.02	CONTRACTUAL ALLOW	1,129,377.46
NON-COVERD CHARGES	236,111.11	TOTAL MEDICAID LIAB	244,318.56
		LESS: COB	0.00
		LESS: COPAYMENT	206.62
		REIMBURSEMENT	244,111.94
		TOTAL NUMBER OF CLAIMS	48

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

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

PROVIDER NUMBER  
 000000866A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,995.17	2,801.86	OTHER LAB	915.22	0.00
MED/SURG SUPPLY	241,000.56	11,096.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,884.34	2,162.12	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,065.48	5,047.89	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	245.52	FEE SCHEDULE LAB	81,599.33	4,275.66
EKG/ECG	6,057.60	841.12	MRI SERVICES	7,143.53	2,931.80
IV THERAPY	4,534.32	922.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	316,363.07	29,326.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,212.78	165.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	186,345.78	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,585.13	4,707.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,254.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	208,454.35	108,216.44
RADIOLOGY THERAPEUTIC	14,371.81	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	303.87	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	508.68	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,776.52	29,803.58
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	718.00	833.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,282.34	4,228.77			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,895.65	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	75,335.52	27,691.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,904.68	0.00			
			TOTAL ANCILLARY	1,373,696.02	236,111.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,373,696.02	236,111.11

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

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

Run Date: 09/24/2013  
Run Time: 16:36:32  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000866A

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

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 16:36:41  
 Page: 1

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER 000000877A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,378,928.36	ADJUSTMENTS	67,887.71
COVERED CHARGES	2,358,393.85	CONTRACTUAL ALLOW	1,064,638.66
NON-COVERD CHARGES	20,534.51	TOTAL MEDICAID LIAB	1,293,755.19
		LESS: COB	4,801.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,288,953.70

TOTAL NUMBER OF ADMISSIONS 304

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	515		0	206,000.00		12,888.00
ROUTINE NURSERY	170		0	45,725.00		650.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	685		0	251,725.00		13,538.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	48		0	47,550.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	48		0	47,550.00		0.00
TOTAL ACCOMODATIONS	733		0	299,275.00		13,538.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	344,282.40	87.75	OTHER LAB	9,098.50	0.00
MED/SURG SUPPLY	151,452.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	284,783.00	598.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,989.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,955.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,778.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,974.50	0.00	MRI SERVICES	18,311.50	0.00
IV THERAPY	158,932.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	106,868.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	233,558.25	1,114.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,348.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,794.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	126,066.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,770.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,228.00	0.00	INJECTABLE DRUGS	51,232.36	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,319.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,484.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	231.51
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,560.25	558.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	182,407.05	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,349.50
OTHER IMAGING SERVICE	5,017.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,822.25	3,057.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,981.00	0.00			
AUDIOLOGY	18,406.25	0.00			
CARDIOLOGY	13,030.75	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	18,666.25	0.00			
			TOTAL ANCILLARY	2,059,118.85	6,996.51
			TOTAL ACCOMODATIONS	299,275.00	13,538.00
			TOTAL CHARGES	2,358,393.85	20,534.51

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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HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212114003790	04/08/12 - 04/13/12	04/30/12	0.00	1,349.50	0.00	0.00	0.00
TOTAL				0.00	1,349.50	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

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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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HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,190,451.48	ADJUSTMENTS	33,540.96
COVERED CHARGES	2,774,891.15	CONTRACTUAL ALLOW	1,982,863.21
NON-COVERD CHARGES	415,560.33	TOTAL MEDICAID LIAB	792,027.94
		LESS: COB	1,649.34
		LESS: COPAYMENT	2,016.00
		REIMBURSEMENT	788,362.60
		ALL OTHER	706,297.07
		FEE SCHEDULE-LAB	70,397.77
		INJECTABLE DRUGS	11,667.76
		TOTAL NUMBER OF CLAIMS	2,642

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

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

Run Date: 09/24/2013  
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HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,726.36	3,637.92	OTHER LAB	68,477.25	0.00
MED/SURG SUPPLY	153,018.94	896.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	804.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,115.00	2,634.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	223,326.32	165,567.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,227.00	4,492.25	FEE SCHEDULE LAB	538,744.50	109,241.75
EKG/ECG	32,594.50	1,039.75	MRI SERVICES	83,397.75	3,362.00
IV THERAPY	37,671.00	1,145.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,294.32	56,847.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,670.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,586.25	637.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,014.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	925,140.74	5,343.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,673.75	142.25	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,663.72	3,750.41
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	209.50	8,554.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,553.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	30.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,857.50	6,903.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,179.75	23,530.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,474.75	3,097.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,150.00	2,502.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	41,028.25	823.00			
AUDIOLOGY	2,829.50	973.00			
CARDIOLOGY	39,383.75	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	36,435.25	691.00			
			TOTAL ANCILLARY	2,774,891.15	412,200.33
			TOTAL ACCOMODATIONS	0.00	3,360.00
			TOTAL CHARGES	2,774,891.15	415,560.33

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

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,737.88	ADJUSTMENTS	0.00
COVERED CHARGES	11,875.23	CONTRACTUAL ALLOW	4,842.44
NON-COVERD CHARGES	4,862.65	TOTAL MEDICAID LIAB	7,032.79
		LESS: COB	7,026.79
		LESS: COPAYMENT	6.00
		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

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	406.68	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	453.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	286.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,502.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,109.25	187.00
EKG/ECG	106.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	965.25	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	526.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,367.25	134.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	768.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127.15	74.40
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	352.50	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	371.50	0.00			
			TOTAL ANCILLARY	11,875.23	4,862.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,875.23	4,862.65



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

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

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HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	271,818.89	ADJUSTMENTS	217.76
COVERED CHARGES	260,742.67	CONTRACTUAL ALLOW	235,178.09
NON-COVERD CHARGES	11,076.22	TOTAL MEDICAID LIAB	25,564.58
		LESS: COB	0.00
		LESS: COPAYMENT	987.01
		REIMBURSEMENT	24,577.57
		TOTAL NUMBER OF CLAIMS	457

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

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,042.07	66.47	OTHER LAB	2,457.00	0.00
MED/SURG SUPPLY	346.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	95.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,199.00	240.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,471.50	6,798.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,550.75	2,586.00
EKG/ECG	2,092.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,345.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	185,175.75	402.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,213.10	224.50
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	54.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,477.00	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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	371.50	0.00			
			TOTAL ANCILLARY	260,742.67	11,076.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	260,742.67	11,076.22

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

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

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HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	520.00	ADJUSTMENTS	0.00
COVERED CHARGES	520.00	CONTRACTUAL ALLOW	299.15
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	220.85
		LESS: COB	220.85
		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

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	475.25	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	32.25	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	520.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	520.00	0.00

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 16:38:07  
 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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,143,192.79	ADJUSTMENTS	5,535,790.03
COVERED CHARGES	81,181,038.22	CONTRACTUAL ALLOW	56,526,231.64
NON-COVERD CHARGES	3,962,154.57	TOTAL MEDICAID LIAB	24,654,806.58
		LESS: COB	135,519.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,519,287.42

TOTAL NUMBER OF ADMISSIONS 3,358

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,506		1	6,883,598.90		2,799,611.00
ROUTINE NURSERY	2,396		0	1,313,807.70		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12,902		1	8,197,406.60		2,799,611.00
SPECIAL CARE SERVICES						
CCU	462		0	751,826.00		1,653.00
ICU	1,316		0	2,170,084.00		13,423.00
NICU	224		0	317,399.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		342	0.00		263,712.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,002		342	3,239,309.00		278,788.00
TOTAL ACCOMODATIONS	14,904		343	11,436,715.60		3,078,399.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,892,438.32	201,488.00	OTHER LAB	352,230.00	722.00
MED/SURG SUPPLY	6,302,766.25	160,708.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,000,056.25	85,671.11	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	993,154.00	6,363.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,471,339.82	9,220.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	291,040.00	4,115.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	510,489.00	2,072.00	MRI SERVICES	642,777.00	9,027.00
IV THERAPY	509,703.74	21,542.00	PROFESSIONAL FEES	0.00	1,316.00
OPERATING ROOM	4,985,439.98	34,357.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,402,230.00	4,217.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,406,642.00	57,118.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,052,218.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,377.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,499,365.65	7,009.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,848,129.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	343,193.00	1,777.00	INJECTABLE DRUGS	6,826,380.41	109,772.78
RADIOLOGY THERAPEUTIC	257,113.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	195,197.50	2,096.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	115,793.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	324,888.00	105,594.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,262.00	410.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,654,281.00	652.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	547,839.00	13,103.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	672,832.00	42,983.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	363,672.00	2,259.00			
AUDIOLOGY	104,476.00	163.00			
CARDIOLOGY	2,803,473.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	154,136.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	179,390.70	0.00			
			TOTAL ANCILLARY	69,744,322.62	883,755.57
			TOTAL ACCOMODATIONS	11,436,715.60	3,078,399.00
			TOTAL CHARGES	81,181,038.22	3,962,154.57



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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,945,598.06	ADJUSTMENTS	0.00
COVERED CHARGES	1,886,314.06	CONTRACTUAL ALLOW	906,142.11
NON-COVERD CHARGES	59,284.00	TOTAL MEDICAID LIAB	980,171.95
		LESS: COB	980,171.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 101

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	300		0	199,248.00		51,963.00
ROUTINE NURSERY	99		0	65,203.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	399		0	264,451.00		51,963.00
SPECIAL CARE SERVICES						
CCU	9		0	14,877.00		0.00
ICU	6		0	9,918.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		8	0.00		6,160.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	15		8	24,795.00		6,160.00
TOTAL ACCOMODATIONS	414		8	289,246.00		58,123.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	248,193.00	0.00	OTHER LAB	10,350.00	0.00
MED/SURG SUPPLY	129,843.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	207,888.65	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,116.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,433.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,492.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,252.00	0.00	MRI SERVICES	10,157.00	0.00
IV THERAPY	9,410.00	0.00	PROFESSIONAL FEES	0.00	1,161.00
OPERATING ROOM	66,498.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	196,379.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,685.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	97,370.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,335.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	111,982.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,086.00	0.00	INJECTABLE DRUGS	113,214.32	0.00
RADIOLOGY THERAPEUTIC	26,727.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,785.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,315.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	18,018.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	820.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,894.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,563.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,956.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,589.00	0.00			
AUDIOLOGY	2,883.00	0.00			
CARDIOLOGY	34,050.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,547.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,236.50	0.00			
			TOTAL ANCILLARY	1,597,068.06	1,161.00
			TOTAL ACCOMODATIONS	289,246.00	58,123.00
			TOTAL CHARGES	1,886,314.06	59,284.00

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

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

Run Date: 09/24/2013  
Run Time: 16:39:47  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,414,780.02	ADJUSTMENTS	1,342,871.05
COVERED CHARGES	34,964,210.39	CONTRACTUAL ALLOW	27,993,431.43
NON-COVERD CHARGES	3,450,569.63	TOTAL MEDICAID LIAB	6,970,778.96
		LESS: COB	13,047.58
		LESS: COPAYMENT	15,575.62
		REIMBURSEMENT	6,942,155.76
		ALL OTHER	5,883,235.96
		FEE SCHEDULE-LAB	587,507.71
		INJECTABLE DRUGS	471,412.09

TOTAL NUMBER OF CLAIMS 13,778

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,942,383.93	5,139.00	OTHER LAB	333,667.00	4,305.00
MED/SURG SUPPLY	1,512,084.35	3,170.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	30.00	EDUCATION & TRAINING	0.00	530.00
RADIOLOGY-DIAGNOSTIC	1,450,698.00	40,854.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,355,527.00	310,683.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	168,565.00	86,064.00	FEE SCHEDULE LAB	6,095,805.51	1,107,306.88
EKG/ECG	355,317.00	26,677.00	MRI SERVICES	1,043,842.00	82,667.00
IV THERAPY	1,243,112.00	107,902.00	PROFESSIONAL FEES	0.00	846.00
OPERATING ROOM	2,194,201.95	804,529.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	92,353.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	181,145.00	25,026.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	710,063.00	3,608.00	AMBULANCE	0.00	0.00
GI SERVICES	8,895.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,625,826.00	95,071.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	854,352.00	2,801.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,321,147.67	237,366.13
RADIOLOGY THERAPEUTIC	1,951,697.00	21,034.00	HOME HEALTH SERVICES	0.00	240.00
OCCUPATIONAL THERAPY	10,335.00	12,720.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,685.00	10,909.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,914.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	9,020.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	66,150.00	4,725.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,336.57
OTHER IMAGING SERVICE	1,297,127.00	174,739.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	75,282.55	57,610.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	563,829.00	3,063.00			
AUDIOLOGY	12,376.00	0.00			
CARDIOLOGY	1,089,452.00	189,514.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	728,803.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	675,488.43	12,170.00			
			TOTAL ANCILLARY	34,964,210.39	3,450,569.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,964,210.39	3,450,569.63

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

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

Run Date: 09/24/2013  
Run Time: 16:39:47  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2605	2212006011615	12/01/11 - 12/01/11	01/09/12	0.00	502.00	0.00	0.00	0.00
905	2012048036788	10/26/11 - 10/26/11	02/20/12	0.00	529.00	0.00	0.00	0.00
905	2012048036788	10/27/11 - 10/27/11	02/20/12	0.00	529.00	0.00	0.00	0.00
905	2012048036788	10/28/11 - 10/28/11	02/20/12	0.00	529.00	0.00	0.00	0.00
905	2012048036788	10/31/11 - 10/31/11	02/20/12	0.00	529.00	0.00	0.00	0.00
905	2012048036788	11/01/11 - 11/01/11	02/20/12	0.00	529.00	0.00	0.00	0.00
905	2012048036788	11/02/11 - 11/02/11	02/20/12	0.00	529.00	0.00	0.00	0.00
905	2212209014916	06/01/12 - 06/01/12	07/30/12	0.00	529.00	0.00	0.00	0.00
905	2212209014916	06/05/12 - 06/05/12	07/30/12	0.00	529.00	0.00	0.00	0.00
905	2212209014971	06/08/12 - 06/08/12	07/30/12	0.00	529.00	0.00	0.00	0.00
639	2213094005267	08/29/12 - 08/29/12	04/08/13	0.00	73.57	0.00	0.00	0.00
TOTAL				0.00	5,336.57	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: 09/24/2013  
Run Time: 16:42:47  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,162,981.81	ADJUSTMENTS	0.00
COVERED CHARGES	1,008,475.65	CONTRACTUAL ALLOW	550,994.74
NON-COVERD CHARGES	154,506.16	TOTAL MEDICAID LIAB	457,480.91
		LESS: COB	457,177.91
		LESS: COPAYMENT	303.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 342

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,194.00	0.00	OTHER LAB	5,935.00	0.00
MED/SURG SUPPLY	88,353.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,214.00	475.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,841.00	13,497.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,764.00	567.00	FEE SCHEDULE LAB	171,859.00	27,695.16
EKG/ECG	7,511.00	0.00	MRI SERVICES	21,088.00	16,165.00
IV THERAPY	28,877.00	2,688.00	PROFESSIONAL FEES	0.00	846.00
OPERATING ROOM	56,570.00	71,430.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,543.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,820.00	600.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,304.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,005.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	159,223.00	1,864.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	53,571.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	58,562.94	5,701.00
RADIOLOGY THERAPEUTIC	27,549.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	246.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,725.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,761.00
OTHER IMAGING SERVICE	39,289.00	3,371.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,813.00	4,600.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,917.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,799.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,360.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,788.50	0.00			
			TOTAL ANCILLARY	1,008,475.65	154,506.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,008,475.65	154,506.16

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012262082627	10/20/11 - 10/20/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	10/21/11 - 10/21/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	10/24/11 - 10/24/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	10/25/11 - 10/25/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	10/26/11 - 10/26/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	10/27/11 - 10/27/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	10/28/11 - 10/28/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	10/31/11 - 10/31/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
905	2012262082627	11/01/11 - 11/01/11	09/24/12	0.00	529.00	0.00	4,352.10	0.00
TOTAL				0.00	4,761.00	0.00	39,168.90	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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,240,889.74	ADJUSTMENTS	1,888.87
COVERED CHARGES	1,187,236.32	CONTRACTUAL ALLOW	1,134,988.36
NON-COVERD CHARGES	53,653.42	TOTAL MEDICAID LIAB	52,247.96
		LESS: COB	0.00
		LESS: COPAYMENT	1,515.06
		REIMBURSEMENT	50,732.90
		TOTAL NUMBER OF CLAIMS	934

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,684.00	80.00	OTHER LAB	3,470.00	0.00
MED/SURG SUPPLY	10,403.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,009.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,048.00	6,306.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,206.00	192.00	FEE SCHEDULE LAB	236,237.00	22,826.42
EKG/ECG	10,878.00	0.00	MRI SERVICES	10,986.00	0.00
IV THERAPY	47,955.00	3,327.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,915.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,170.00	664.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	636,489.00	3,005.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,352.95	2,093.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	164.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,789.00	3,400.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	11,596.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,643.50	0.00			
			TOTAL ANCILLARY	1,187,236.32	53,653.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,187,236.32	53,653.42

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	103,598.67	ADJUSTMENTS	0.00
COVERED CHARGES	93,258.40	CONTRACTUAL ALLOW	70,015.54
NON-COVERD CHARGES	10,340.27	TOTAL MEDICAID LIAB	23,242.86
		LESS: COB	23,191.82
		LESS: COPAYMENT	51.04
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 27

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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,301.03	271.00	OTHER LAB	875.00	0.00
MED/SURG SUPPLY	990.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,398.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,241.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	359.00	FEE SCHEDULE LAB	17,267.00	2,743.27
EKG/ECG	1,554.00	0.00	MRI SERVICES	4,365.00	0.00
IV THERAPY	4,546.00	513.00	PROFESSIONAL FEES	0.00	141.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	217.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,777.00	390.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,751.37	1,682.00
RADIOLOGY THERAPEUTIC	2,270.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,530.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,417.00	0.00			
			TOTAL ANCILLARY	93,258.40	10,340.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,258.40	10,340.27

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,825,372.90	ADJUSTMENTS	431,701.71
COVERED CHARGES	7,115,087.31	CONTRACTUAL ALLOW	5,924,144.10
NON-COVERD CHARGES	710,285.59	TOTAL MEDICAID LIAB	1,190,943.21
		LESS: COB	507.05
		LESS: COPAYMENT	1,956.00
		REIMBURSEMENT	1,188,480.16

TOTAL NUMBER OF CLAIMS 231

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	367,816.72	615.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,050,241.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	75,883.00	23,672.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,595.00	1,475.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	98.00	890.00	FEE SCHEDULE LAB	193,508.00	40,232.59
EKG/ECG	27,195.00	3,885.00	MRI SERVICES	4,309.00	3,773.00
IV THERAPY	168,656.00	7,202.00	PROFESSIONAL FEES	0.00	47.00
OPERATING ROOM	663,503.00	464,364.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,101.00	687.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	227,992.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,094.00	390.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,238.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,735,683.69	14,714.00
RADIOLOGY THERAPEUTIC	975,210.00	3,406.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	328.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,642.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,393.00	21,102.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,891.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	287,657.00	123,296.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,222.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,158.44	207.00			
			TOTAL ANCILLARY	7,115,087.31	710,285.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,115,087.31	710,285.59

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,210.96	ADJUSTMENTS	0.00
COVERED CHARGES	75,107.78	CONTRACTUAL ALLOW	45,025.37
NON-COVERD CHARGES	14,103.18	TOTAL MEDICAID LIAB	30,082.41
		LESS: COB	30,073.41
		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  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
743 SPRING ST NE	000000888A	SERVICE DATES	10/01/11	THROUGH	09/30/12
GAINESVILLE,GA 30501-3715		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,793.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,539.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	150.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,400.00	1,170.18
EKG/ECG	518.00	1,295.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,296.00	774.00	PROFESSIONAL FEES	0.00	329.00
OPERATING ROOM	10,611.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,310.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,009.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,565.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,432.68	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	82.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,692.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,899.00	10,453.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,893.10	0.00			
			TOTAL ANCILLARY	75,107.78	14,103.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	75,107.78	14,103.18

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000899A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,231,442.57	ADJUSTMENTS	1,556,558.10
COVERED CHARGES	25,552,379.60	CONTRACTUAL ALLOW	16,814,553.54
NON-COVERD CHARGES	679,062.97	TOTAL MEDICAID LIAB	8,737,826.06
		LESS: COB	72,623.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,665,203.05

TOTAL NUMBER OF ADMISSIONS 1,519

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,716		0	3,363,301.18		213,796.82
ROUTINE NURSERY	1,116		0	1,016,920.88		2,846.12
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,832		0	4,380,222.06		216,642.94
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	493		0	1,068,111.00		0.00
NICU	282		0	694,800.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	775		0	1,762,911.00		0.00
TOTAL ACCOMODATIONS	6,607		0	6,143,133.06		216,642.94

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,464,330.37	5,784.67	OTHER LAB	84,176.43	0.00
MED/SURG SUPPLY	980,367.22	16,655.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,854,921.41	11,738.24	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	490,618.15	0.00	OTHER THERAPEUTIC SVC	0.00	2,293.80
CT SCAN	728,415.54	24,567.44	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	112,500.79	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	192,321.24	0.00	MRI SERVICES	375,162.53	5,646.72
IV THERAPY	315,744.33	13,047.53	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,082,212.49	31,811.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,279,608.85	240.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,538,251.40	4,713.66	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,948.53	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,721.52	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	488,143.95	328.12	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	191,186.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	108,071.03	0.00	INJECTABLE DRUGS	1,692,780.74	292.50
RADIOLOGY THERAPEUTIC	97,988.29	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	33,929.68	128.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	59,038.58	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	257,726.92	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	819.00	2,524.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	232,124.86	181,949.48	IMPL DEV CHARGE PATIENTS	293,319.33	645.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	31,674.72
OTHER IMAGING SERVICE	175,200.90	5,202.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	213,149.65	106,740.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	95,099.77	12,639.35			
AUDIOLOGY	41,334.60	0.00			
CARDIOLOGY	727,499.23	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,200.14	0.00			
ORGAN ACQUISITION	0.00	3,797.59			
TREATMENT/OBSERV. RM	65,332.37	0.00			
			TOTAL ANCILLARY	19,409,246.54	462,420.03
			TOTAL ACCOMODATIONS	6,143,133.06	216,642.94
			TOTAL CHARGES	25,552,379.60	679,062.97

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

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212191000377	06/20/12 - 06/22/12	07/16/12	0.00	2,892.00	0.00	0.00	0.00
615	2012191027779	05/13/12 - 05/16/12	07/16/12	0.00	2,892.00	0.00	0.00	0.00
615	2012192054673	06/14/12 - 06/29/12	07/16/12	0.00	2,892.00	0.00	0.00	0.00
615	2012229101432	07/28/12 - 08/07/12	08/20/12	0.00	1,446.00	0.00	0.00	0.00
615	2012234054401	08/02/12 - 08/10/12	08/27/12	0.00	1,446.00	0.00	0.00	0.00
615	2012251032857	08/18/12 - 08/20/12	09/10/12	0.00	2,892.00	0.00	0.00	0.00
615	2012279058799	07/30/12 - 08/05/12	10/15/12	0.00	1,446.00	0.00	0.00	0.00
615	2212292017082	01/19/12 - 02/20/12	10/22/12	0.00	2,754.72	0.00	0.00	0.00
615	2212303009833	07/07/12 - 07/08/12	11/05/12	0.00	1,446.00	0.00	0.00	0.00
615	2012355069247	09/03/12 - 09/05/12	12/24/12	0.00	2,892.00	0.00	0.00	0.00
615	2013049034674	06/23/12 - 06/30/12	02/25/13	0.00	2,892.00	0.00	0.00	0.00
615	2013087045936	09/28/12 - 10/01/12	04/01/13	0.00	2,892.00	0.00	0.00	0.00
615	5213211000214	07/10/12 - 07/22/12	08/05/13	0.00	2,892.00	0.00	0.00	0.00
TOTAL				0.00	31,674.72	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: 09/24/2013  
 Run Time: 16:44:16  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	151,556.70	ADJUSTMENTS	0.00
COVERED CHARGES	150,437.12	CONTRACTUAL ALLOW	63,580.88
NON-COVERD CHARGES	1,119.58	TOTAL MEDICAID LIAB	86,856.24
		LESS: COB	86,856.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14		0	12,624.42		486.58
ROUTINE NURSERY	11		0	15,364.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	25		0	27,988.42		486.58
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	5		0	10,410.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	10,410.00		0.00
TOTAL ACCOMODATIONS	30		0	38,398.42		486.58

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,891.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,313.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	21,608.06	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,763.12	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,969.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	256.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,451.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	33,209.78	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,904.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,428.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,346.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	652.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,796.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,010.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,381.54	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,778.00	633.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	279.66	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	112,038.70	633.00
			TOTAL ACCOMODATIONS	38,398.42	486.58
			TOTAL CHARGES	150,437.12	1,119.58

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: 09/24/2013  
Run Time: 16:44:19  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,828,882.45	ADJUSTMENTS	591,536.23
COVERED CHARGES	19,612,169.74	CONTRACTUAL ALLOW	16,092,293.94
NON-COVERD CHARGES	2,216,712.71	TOTAL MEDICAID LIAB	3,519,875.80
		LESS: COB	1,213.48
		LESS: COPAYMENT	6,753.15
		REIMBURSEMENT	3,511,909.17
		ALL OTHER	3,069,649.51
		FEE SCHEDULE-LAB	332,623.85
		INJECTABLE DRUGS	109,635.81

TOTAL NUMBER OF CLAIMS 9,122

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

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	509,317.68	7,907.09	OTHER LAB	111,252.03	5,853.30
MED/SURG SUPPLY	496,433.41	7,658.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,304.99	EDUCATION & TRAINING	7,906.08	0.00
RADIOLOGY-DIAGNOSTIC	1,144,628.07	21,517.58	OTHER THERAPEUTIC SVC	0.00	25,602.99
CT SCAN	1,504,855.04	98,109.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,061.64	9,146.46	FEE SCHEDULE LAB	5,330,252.96	1,054,379.84
EKG/ECG	406,069.60	16,742.30	MRI SERVICES	1,045,817.01	95,484.92
IV THERAPY	1,097,523.16	352,683.67	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,170,779.02	211,961.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	62,239.06	0.00	REHAB THERAPY	2,710.90	0.00
RESPIRATORY SERVICES	188,745.41	35,236.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	86,632.87	570.83	AMBULANCE	0.00	0.00
GI SERVICES	3,237.43	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,136,038.62	2,493.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	182,796.52	1,349.64	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	285.17	INJECTABLE DRUGS	474,200.52	131,574.57
RADIOLOGY THERAPEUTIC	567,630.59	19,743.38	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,028.05	500.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,298.21	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,097.94	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	75,092.42	3,213.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	212.80	IMPL DEV CHARGE PATIENTS	31,021.23	32,522.87
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,911.53
OTHER IMAGING SERVICE	1,065,527.93	39,329.29			
BLOOD	40,813.37	0.00			
BLOOD STORAGE & PRO.	19,203.70	1,266.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	319,983.04	8,489.78			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	627,181.76	10,107.54			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	363,439.77	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	480,750.85	159.00			
			TOTAL ANCILLARY	19,612,169.74	2,216,712.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,612,169.74	2,216,712.71

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

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

Run Date: 09/24/2013  
Run Time: 16:44:19  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	5912038000216	01/17/12 - 01/17/12	02/13/12	0.00	269.14	0.00	0.00	0.00
3000	2212240009212	01/31/12 - 01/31/12	09/03/12	0.00	196.39	0.00	0.00	0.00
9636	2212277008924	08/16/12 - 08/16/12	10/08/12	0.00	0.00	0.00	0.00	0.00
615	2012338040849	07/24/12 - 07/24/12	12/10/12	0.00	1,446.00	0.00	0.00	0.00
TOTAL				0.00	1,911.53	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: 09/24/2013  
Run Time: 16:46:17  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	304,259.24	ADJUSTMENTS	0.00
COVERED CHARGES	275,728.30	CONTRACTUAL ALLOW	148,283.10
NON-COVERD CHARGES	28,530.94	TOTAL MEDICAID LIAB	127,445.20
		LESS: COB	127,328.20
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 111

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,139.37	0.00	OTHER LAB	1,585.10	792.55
MED/SURG SUPPLY	8,799.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	149.17	EDUCATION & TRAINING	413.24	0.00
RADIOLOGY-DIAGNOSTIC	11,169.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,776.93	5,487.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,263.04	0.00	FEE SCHEDULE LAB	64,168.51	10,719.13
EKG/ECG	4,507.04	778.14	MRI SERVICES	15,251.00	0.00
IV THERAPY	13,810.10	2,751.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,405.01	1,572.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,610.82	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,536.11	244.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,619.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,642.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,167.77	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,389.70	686.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,974.91	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	90.79
OTHER IMAGING SERVICE	24,832.34	1,012.60			
BLOOD	1,054.24	0.00			
BLOOD STORAGE & PRO.	603.05	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,173.23	2,615.73			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,767.15	1,420.69			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,834.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,210.63	0.00			
			TOTAL ANCILLARY	275,728.30	28,320.74
			TOTAL ACCOMODATIONS	0.00	210.20
			TOTAL CHARGES	275,728.30	28,530.94

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

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

Run Date: 09/24/2013  
Run Time: 16:46:17  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	2211354010366	11/08/11 - 11/08/11	12/26/11	0.00	90.79	0.00	1,457.86	0.00
TOTAL				0.00	90.79	0.00	1,457.86	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: 09/24/2013  
Run Time: 16:46:22  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,022,617.78	ADJUSTMENTS	3,676.80
COVERED CHARGES	972,765.09	CONTRACTUAL ALLOW	909,758.55
NON-COVERD CHARGES	49,852.69	TOTAL MEDICAID LIAB	63,006.54
		LESS: COB	10.00
		LESS: COPAYMENT	2,628.17
		REIMBURSEMENT	60,368.37
		TOTAL NUMBER OF CLAIMS	1,127

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,786.23	251.70	OTHER LAB	7,779.50	0.00
MED/SURG SUPPLY	8,033.32	16.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,096.97	875.27	OTHER THERAPEUTIC SVC	0.00	5,390.43
CT SCAN	45,295.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	297,024.72	25,700.56
EKG/ECG	11,716.50	0.00	MRI SERVICES	12,958.00	2,892.00
IV THERAPY	66,201.93	9,578.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,404.98	1,200.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	481.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,527.50	244.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	430.01	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	362,611.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	449.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,131.40	3,637.35
RADIOLOGY THERAPEUTIC	565.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	483.00	66.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,882.53	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,097.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,808.76	0.00			
			TOTAL ANCILLARY	972,765.09	49,852.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	972,765.09	49,852.69

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

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

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,819.76	ADJUSTMENTS	0.00
COVERED CHARGES	5,778.39	CONTRACTUAL ALLOW	3,540.91
NON-COVERD CHARGES	41.37	TOTAL MEDICAID LIAB	2,237.48
		LESS: COB	2,228.47
		LESS: COPAYMENT	9.01
		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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	662.63	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	2,702.61	41.37
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	1,442.40	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	71.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	720.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,778.39	41.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,778.39	41.37

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

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

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,123,760.96	ADJUSTMENTS	40,961.84
COVERED CHARGES	2,027,137.28	CONTRACTUAL ALLOW	1,756,374.64
NON-COVERD CHARGES	96,623.68	TOTAL MEDICAID LIAB	270,762.64
		LESS: COB	4,374.62
		LESS: COPAYMENT	1,139.42
		REIMBURSEMENT	265,248.60

TOTAL NUMBER OF CLAIMS 53



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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,449.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	43,667.93	822.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,348.12	16,860.93	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,962.12	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,560.51	16,169.32
EKG/ECG	6,349.52	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	54,984.49	1,230.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	360,943.61	1,980.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,139.64	297.16	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,190.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	864.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,185.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	389,180.15	20,414.70
RADIOLOGY THERAPEUTIC	635,498.70	23,458.27	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	384.56	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	115,415.98	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,390.57	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	182,542.50	15,390.53			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,080.00	0.00			
			TOTAL ANCILLARY	2,027,137.28	96,623.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,027,137.28	96,623.68

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

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

Run Date: 09/24/2013  
Run Time: 16:46:41  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000899A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 16:56:57  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER 000000943A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	198,182,283.76	ADJUSTMENTS	40,489,966.57
COVERED CHARGES	190,654,658.07	CONTRACTUAL ALLOW	115,035,146.39
NON-COVERD CHARGES	7,527,625.69	TOTAL MEDICAID LIAB	75,619,511.68
		LESS: COB	97,747.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	75,521,763.79

TOTAL NUMBER OF ADMISSIONS 3,093

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	13,970		39	12,623,482.00		4,654,678.00
ROUTINE NURSERY	1,367		0	2,715,713.00		10,529.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15,337		39	15,339,195.00		4,665,207.50
SPECIAL CARE SERVICES						
CCU	1,412		0	4,695,867.00		3,321.00
ICU	43		1	59,052.00		1,368.00
NICU	1,811		0	8,054,600.50		0.00
PED ICU	4,005		14	13,305,836.00		65,836.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7,271		15	26,115,355.50		70,525.00
TOTAL ACCOMODATIONS	22,608		54	41,454,550.50		4,735,732.50

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,953,123.91	513,781.39	OTHER LAB	460,435.50	1,745.00
MED/SURG SUPPLY	11,434,028.35	320,690.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,666,184.56	385,751.29	EDUCATION & TRAINING	458.00	0.00
RADIOLOGY-DIAGNOSTIC	3,308,802.50	12,131.50	OTHER THERAPEUTIC SVC	72,248.50	110,180.10
CT SCAN	1,302,426.00	60,580.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	840,975.50	8,159.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	191,640.00	664.00	MRI SERVICES	1,272,667.00	10,362.50
IV THERAPY	77,523.50	16,758.00	PROFESSIONAL FEES	0.00	15,047.50
OPERATING ROOM	17,623,604.00	101,262.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,909,593.26	157,341.53	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,262,515.50	80,210.00	AMBULANCE	0.00	0.00
GI SERVICES	21,170.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,198,149.00	41,029.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,200,232.00	18,151.50	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,039,098.50	4,353.00	INJECTABLE DRUGS	15,767.75	891.50
RADIOLOGY THERAPEUTIC	257,342.50	1,467.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	337,513.00	3,984.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	456,022.00	4,434.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	84,122.50	147,758.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	450.00	65,347.00	TRAUMA RESPONSE	0.00	37,764.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,555,785.50	137,817.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	492,777.50	105,755.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,709,157.99	41,233.51			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	96,397.00	6,210.00			
AUDIOLOGY	27,463.50	163.00			
CARDIOLOGY	3,957,374.50	6,097.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,739,455.00	0.00			
ORGAN ACQUISITION	1,530,384.50	374,227.50			
TREATMENT/OBSERV. RM	105,218.75	543.50			
			TOTAL ANCILLARY	149,200,107.57	2,791,893.19
			TOTAL ACCOMODATIONS	41,454,550.50	4,735,732.50
			TOTAL CHARGES	190,654,658.07	7,527,625.69

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

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

Run Date: 09/24/2013  
 Run Time: 16:57:56  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,932,466.39	ADJUSTMENTS	0.00
COVERED CHARGES	4,849,287.89	CONTRACTUAL ALLOW	1,810,191.21
NON-COVERD CHARGES	83,178.50	TOTAL MEDICAID LIAB	3,039,096.68
		LESS: COB	3,039,096.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 72

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	303		0	276,793.00		64,101.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	303		0	276,793.00		64,101.00
SPECIAL CARE SERVICES						
CCU	16		0	53,136.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	23		0	76,383.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	39		0	129,519.00		0.00
TOTAL ACCOMODATIONS	342		0	406,312.00		64,101.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	827,273.25	0.00	OTHER LAB	28,445.00	0.00
MED/SURG SUPPLY	391,604.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	378,981.13	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,192.50	0.00	OTHER THERAPEUTIC SVC	142.00	3,075.00
CT SCAN	31,835.00	2,640.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,566.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,315.00	0.00	MRI SERVICES	34,244.00	0.00
IV THERAPY	1,456.50	0.00	PROFESSIONAL FEES	0.00	12,483.50
OPERATING ROOM	854,305.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	135,128.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	328,107.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,438.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,661.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,827.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	39,803.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,007.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,872.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	878.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,004,397.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,938.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,817.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	981.50	0.00			
AUDIOLOGY	572.00	0.00			
CARDIOLOGY	73,369.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,483.00	0.00			
ORGAN ACQUISITION	3,094.00	0.00			
TREATMENT/OBSERV. RM	10,120.00	0.00			
			TOTAL ANCILLARY	4,442,975.89	19,077.50
			TOTAL ACCOMODATIONS	406,312.00	64,101.00
			TOTAL CHARGES	4,849,287.89	83,178.50

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: 09/24/2013  
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CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1060

PROVIDER NUMBER  
000000943A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,471,971.22	ADJUSTMENTS	4,321,008.55
COVERED CHARGES	49,218,051.89	CONTRACTUAL ALLOW	35,305,649.88
NON-COVERD CHARGES	3,253,919.33	TOTAL MEDICAID LIAB	13,912,402.01
		LESS: COB	61,392.30
		LESS: COPAYMENT	186.00
		REIMBURSEMENT	13,850,823.71
		ALL OTHER	12,147,874.16
		FEE SCHEDULE-LAB	700,564.09
		INJECTABLE DRUGS	1,002,385.46

TOTAL NUMBER OF CLAIMS 19,962

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,959,367.25	50,179.00	OTHER LAB	313,583.15	2,214.50
MED/SURG SUPPLY	2,504,924.49	1,001.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,498,976.50	18,873.50	OTHER THERAPEUTIC SVC	420.00	0.00
CT SCAN	1,392,073.00	90,188.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	93,051.50	9,516.00	FEE SCHEDULE LAB	8,935,410.23	1,498,505.90
EKG/ECG	108,406.00	1,393.00	MRI SERVICES	3,108,128.50	277,585.00
IV THERAPY	1,039,190.00	19,673.00	PROFESSIONAL FEES	0.00	21,619.00
OPERATING ROOM	5,271,000.07	531,500.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	826,031.50	5,404.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,162,617.00	900.00	AMBULANCE	0.00	0.00
GI SERVICES	73,604.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,706,456.00	75,522.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,405,379.00	520.50	DRUG-SPECIFIC/HOME IV	394.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,511,504.75	286,432.00
RADIOLOGY THERAPEUTIC	809,844.00	3,492.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,100.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	328,841.00	6,676.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	20,790.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,318,438.00	63,730.50	TRAUMA RESPONSE	0.00	13,914.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	510,583.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	650,308.50	10,689.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	695,992.50	6,703.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	344,558.50	23,430.50			
AUDIOLOGY	239,708.00	0.00			
CARDIOLOGY	1,226,000.50	102,529.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,537,892.00	0.00			
ORGAN ACQUISITION	0.00	106,237.50			
TREATMENT/OBSERV. RM	625,267.20	4,697.50			
			TOTAL ANCILLARY	49,218,051.89	3,253,919.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,218,051.89	3,253,919.33



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

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

Run Date: 09/24/2013  
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CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1060

PROVIDER NUMBER  
000000943A

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

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3	2212174010144	04/05/12 - 04/05/12	06/25/12	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: 09/24/2013  
Run Time: 17:00:24  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1060

PROVIDER NUMBER  
000000943A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,664,200.48	ADJUSTMENTS	0.00
COVERED CHARGES	2,036,202.69	CONTRACTUAL ALLOW	515,782.81
NON-COVERD CHARGES	627,997.79	TOTAL MEDICAID LIAB	1,520,419.88
		LESS: COB	1,520,404.88
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 742

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

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,153.50	49,525.50	OTHER LAB	5,882.50	2,087.00
MED/SURG SUPPLY	157,442.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,362.50	960.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,556.50	8,065.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,312.00	166.00	FEE SCHEDULE LAB	347,797.44	60,132.54
EKG/ECG	6,980.00	0.00	MRI SERVICES	176,343.50	23,389.50
IV THERAPY	11,548.00	992.00	PROFESSIONAL FEES	0.00	47,301.50
OPERATING ROOM	252,476.50	176,311.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,800.00	5,920.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	235,177.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	127,132.50	4,973.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	81,767.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	137,173.75	69,597.25
RADIOLOGY THERAPEUTIC	43,350.50	3,120.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	919.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,397.50	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	40,274.50	1,004.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,202.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,538.50	26,357.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,348.00	7,080.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,041.00	3,007.50			
AUDIOLOGY	6,022.00	0.00			
CARDIOLOGY	27,360.50	138,007.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	47,563.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,279.50	0.00			
			TOTAL ANCILLARY	2,036,202.69	627,997.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,036,202.69	627,997.79

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

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

Run Date: 09/24/2013  
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CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1060

PROVIDER NUMBER  
000000943A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,418,594.25	ADJUSTMENTS	3,906.79
COVERED CHARGES	1,329,144.75	CONTRACTUAL ALLOW	1,258,660.38
NON-COVERD CHARGES	89,449.50	TOTAL MEDICAID LIAB	70,484.37
		LESS: COB	0.00
		LESS: COPAYMENT	21.01
		REIMBURSEMENT	70,463.36
		TOTAL NUMBER OF CLAIMS	1,260

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,018.25	5,596.75	OTHER LAB	4,337.50	0.00
MED/SURG SUPPLY	54,975.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	92,351.00	1,424.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,514.50	8,728.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,237.50	FEE SCHEDULE LAB	213,203.50	52,268.75
EKG/ECG	1,768.00	221.00	MRI SERVICES	6,800.00	2,006.00
IV THERAPY	926.00	1,232.50	PROFESSIONAL FEES	0.00	4,190.50
OPERATING ROOM	30,132.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,159.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,948.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	767,137.50	6,956.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,870.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,535.25	634.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	409.50	415.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,021.00	0.00	TRAUMA RESPONSE	0.00	2,318.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,467.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,146.50	516.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,290.00	885.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,844.00	0.00			
CARDIOLOGY	2,696.50	820.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,873.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,720.00	0.00			
			TOTAL ANCILLARY	1,329,144.75	89,449.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,329,144.75	89,449.50

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: 09/24/2013  
Run Time: 17:00:41  
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CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1060

PROVIDER NUMBER  
000000943A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,400.50	ADJUSTMENTS	0.00
COVERED CHARGES	36,185.50	CONTRACTUAL ALLOW	10,800.06
NON-COVERD CHARGES	11,215.00	TOTAL MEDICAID LIAB	25,385.44
		LESS: COB	25,385.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	34

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

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

Run Date: 09/24/2013  
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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 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,499.75	957.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	780.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,178.50	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	3,788.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	10,197.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	305.00	61.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,874.50	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	398.50	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	2,360.00	0.00			
			TOTAL ANCILLARY	36,185.50	11,215.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,185.50	11,215.00

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

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1060

PROVIDER NUMBER  
000000943A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,664,719.14	ADJUSTMENTS	1,157,732.34
COVERED CHARGES	12,351,337.74	CONTRACTUAL ALLOW	10,139,753.13
NON-COVERD CHARGES	1,313,381.40	TOTAL MEDICAID LIAB	2,211,584.61
		LESS: COB	156,517.47
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	2,055,052.14

TOTAL NUMBER OF CLAIMS 288



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

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	734,609.00	25,246.00	OTHER LAB	7,505.50	782.50
MED/SURG SUPPLY	1,665,011.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	449,523.00	74,758.50	OTHER THERAPEUTIC SVC	71.00	0.00
CT SCAN	13,555.50	1,973.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,715.50	5,054.00	FEE SCHEDULE LAB	394,834.50	158,266.65
EKG/ECG	6,841.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	78,158.00	11,298.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,449,191.50	194,154.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,737.00	122.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	967,448.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,934.00	303.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	202,235.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,488,131.51	22,046.25
RADIOLOGY THERAPEUTIC	19,169.50	520.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	985.00	83.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	512.50	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	4,025.00	1,429.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,973,228.41	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,482.50	891.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,563.00	5,469.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,565.00	257.00			
AUDIOLOGY	327.00	0.00			
CARDIOLOGY	1,762,384.50	810,214.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,808.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	60,297.50	0.00			
			TOTAL ANCILLARY	12,351,337.74	1,313,381.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,351,337.74	1,313,381.40

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: 09/24/2013  
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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 30322-1060

PROVIDER NUMBER  
000000943A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	644,633.75	ADJUSTMENTS	0.00
COVERED CHARGES	604,720.50	CONTRACTUAL ALLOW	187,701.43
NON-COVERD CHARGES	39,913.25	TOTAL MEDICAID LIAB	417,019.07
		LESS: COB	417,019.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1060

PROVIDER NUMBER  
 000000943A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,226.25	3,628.75	OTHER LAB	353.00	0.00
MED/SURG SUPPLY	39,079.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,207.00	1,929.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	902.00	FEE SCHEDULE LAB	3,841.00	928.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	532.00	519.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	82,131.00	10,360.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	122.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,743.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,321.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39,070.25	343.50
RADIOLOGY THERAPEUTIC	821.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	341,089.50	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	1,517.00	0.00			
CARDIOLOGY	3,284.50	21,302.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,382.50	0.00			
			TOTAL ANCILLARY	604,720.50	39,913.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	604,720.50	39,913.25

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSPITAL  
 200 ALLEN MEMORIAL DR  
 BREMEN,GA 30110-2012

PROVIDER NUMBER 000000954A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,265,914.12	ADJUSTMENTS	22,910.08
COVERED CHARGES	1,251,576.12	CONTRACTUAL ALLOW	798,691.24
NON-COVERD CHARGES	14,338.00	TOTAL MEDICAID LIAB	452,884.88
		LESS: COB	2,837.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	450,047.46

TOTAL NUMBER OF ADMISSIONS 62

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	68		0	60,709.00		893.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		15	0.00		13,395.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	68		15	60,709.00		14,288.00
SPECIAL CARE SERVICES						
CCU	70		0	97,230.00		0.00
ICU	46		0	97,520.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	116		0	194,750.00		0.00
TOTAL ACCOMODATIONS	184		15	255,459.00		14,288.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,150.37	0.00	OTHER LAB	4,180.00	0.00
MED/SURG SUPPLY	69,512.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	258,359.00	0.00	EDUCATION & TRAINING	294.00	0.00
RADIOLOGY-DIAGNOSTIC	22,776.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,100.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,685.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	13,400.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,752.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,349.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80,047.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,932.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	79,638.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,132.00	0.00	INJECTABLE DRUGS	59,193.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,244.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,885.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	690.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	50.00
OTHER IMAGING SERVICE	6,120.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,205.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	32,934.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	49,752.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,786.00	0.00			
			TOTAL ANCILLARY	996,117.12	50.00
			TOTAL ACCOMODATIONS	255,459.00	14,288.00
			TOTAL CHARGES	1,251,576.12	14,338.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012207046604	06/26/12 - 06/27/12	07/30/12	0.00	50.00	0.00	0.00	0.00
TOTAL				0.00	50.00	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: 09/24/2013  
Run Time: 17:01:14  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 17:01:15  
Page: 5

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,953,757.87	ADJUSTMENTS	309,393.59
COVERED CHARGES	4,618,913.57	CONTRACTUAL ALLOW	3,341,531.49
NON-COVERD CHARGES	334,844.30	TOTAL MEDICAID LIAB	1,277,382.08
		LESS: COB	1,166.66
		LESS: COPAYMENT	4,627.74
		REIMBURSEMENT	1,271,587.68
		ALL OTHER	1,196,239.41
		FEE SCHEDULE-LAB	69,586.88
		INJECTABLE DRUGS	5,761.39
		TOTAL NUMBER OF CLAIMS	3,010



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

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

Run Date: 09/24/2013  
 Run Time: 17:01:15  
 Page: 6

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	266,621.77	4,455.52	OTHER LAB	25,840.00	0.00
MED/SURG SUPPLY	198,898.92	81.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	38.00
RADIOLOGY-DIAGNOSTIC	273,991.00	6,699.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	760,900.00	35,400.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	144,674.00	4,628.00	FEE SCHEDULE LAB	841,817.70	134,373.80
EKG/ECG	53,650.00	1,200.00	MRI SERVICES	238,200.00	3,400.00
IV THERAPY	174,507.00	7,446.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	196,535.50	66,606.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,581.40	7,526.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	141,525.00	22,316.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	829,811.05	8,314.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,404.59	18,900.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,162.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,954.64	746.25
LITHOTRIPSY	47,000.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	87,160.00	6,260.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,485.00	570.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	122,203.00	3,642.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,683.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,440.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,030.00	78.00			
			TOTAL ANCILLARY	4,618,913.57	334,844.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,618,913.57	334,844.30

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,568.64	ADJUSTMENTS	0.00
COVERED CHARGES	11,044.64	CONTRACTUAL ALLOW	9,249.30
NON-COVERD CHARGES	5,524.00	TOTAL MEDICAID LIAB	1,795.34
		LESS: COB	1,774.34
		LESS: COPAYMENT	21.00
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,010.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	818.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,540.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,083.00	142.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,467.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	250.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,332.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,951.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	175.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,044.64	5,524.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,044.64	5,524.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	286,404.26	ADJUSTMENTS	1,325.00
COVERED CHARGES	278,545.51	CONTRACTUAL ALLOW	257,945.51
NON-COVERD CHARGES	7,858.75	TOTAL MEDICAID LIAB	20,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	903.01
		REIMBURSEMENT	19,696.99
		TOTAL NUMBER OF CLAIMS	412

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,475.50	0.00	OTHER LAB	980.00	0.00
MED/SURG SUPPLY	4,030.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,385.00	154.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,700.00	1,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,436.00	4,232.00
EKG/ECG	2,600.00	0.00	MRI SERVICES	2,840.00	0.00
IV THERAPY	16,465.00	325.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,647.50	181.50	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	133,026.75	795.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,819.76	175.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	46.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,140.00	350.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	278,545.51	7,858.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	278,545.51	7,858.75

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

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

Run Date: 09/24/2013  
Run Time: 17:02:50  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 17:02:51  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	298,688.37	ADJUSTMENTS	18,592.80
COVERED CHARGES	270,673.58	CONTRACTUAL ALLOW	233,463.98
NON-COVERD CHARGES	28,014.79	TOTAL MEDICAID LIAB	37,209.60
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	37,179.60

TOTAL NUMBER OF CLAIMS 8

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,855.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,591.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,945.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,600.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,610.00	2,102.00
EKG/ECG	800.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,487.00	195.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,539.00	25,011.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	726.00	121.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,106.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,293.59	585.79
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	154,830.36	0.00
LITHOTRIPSY	23,500.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,200.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,193.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,397.00	0.00			
			TOTAL ANCILLARY	270,673.58	28,014.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	270,673.58	28,014.79



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

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

Run Date: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:03:03  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER  
 1601 WATSON BLVD  
 WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER 000000976A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,758,335.71	ADJUSTMENTS	1,389,457.48
COVERED CHARGES	20,541,044.02	CONTRACTUAL ALLOW	13,197,242.26
NON-COVERD CHARGES	1,217,291.69	TOTAL MEDICAID LIAB	7,343,801.76
		LESS: COB	81,653.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,262,148.31

TOTAL NUMBER OF ADMISSIONS 1,319

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,612		0	2,943,234.00		1,144,294.00
ROUTINE NURSERY	489		0	273,455.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,101		0	3,216,689.00		1,144,294.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	604		0	866,301.00		0.00
NICU	11		0	20,856.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	615		0	887,157.00		0.00
TOTAL ACCOMODATIONS	5,716		0	4,103,846.00		1,144,294.00

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

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

Run Date: 09/24/2013  
 Run Time: 17:03:03  
 Page: 2

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,914,775.65	4,041.91	OTHER LAB	147,365.08	0.00
MED/SURG SUPPLY	716,449.37	15,489.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,703,879.09	14,392.27	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	563,758.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,715,367.56	10,801.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	160,139.52	960.52	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	270,769.97	0.00	MRI SERVICES	527,841.83	0.00
IV THERAPY	6,159.31	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	747,055.84	6,820.53	DURABLE MED. EQUIP.	0.00	547.73
LABOR/DELIVERY ROOM	926,165.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	981,530.52	7,331.97	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,823.94	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	730,605.20	1,788.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	104,197.63	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	65,915.04	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	47,170.28	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	120,999.52	1,437.44	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,973.58	2,320.47	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	19,950.00	0.00	IMPL DEV CHARGE PATIENTS	197,942.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,528.58
OTHER IMAGING SERVICE	188,061.13	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	214,001.11	1,756.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	105,086.67	1,093.38			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,004,164.62	360.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	67,855.37	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	114,192.62	327.53			
			TOTAL ANCILLARY	16,437,198.02	72,997.69
			TOTAL ACCOMODATIONS	4,103,846.00	1,144,294.00
			TOTAL CHARGES	20,541,044.02	1,217,291.69

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: 09/24/2013  
Run Time: 17:03:03  
Page: 3

HOUSTON MEDICAL CENTER  
1601 WATSON BLVD  
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER  
000000976A

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

PART III NO COST CENTER OR 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	9112268011371	05/26/12 - 05/30/12	10/08/12	0.00	3,528.58	0.00	1,172.45	0.00
TOTAL				0.00	3,528.58	0.00	1,172.45	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: 09/24/2013  
 Run Time: 17:03:52  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	336,412.20	ADJUSTMENTS	0.00
COVERED CHARGES	326,252.20	CONTRACTUAL ALLOW	181,975.64
NON-COVERD CHARGES	10,160.00	TOTAL MEDICAID LIAB	144,276.56
		LESS: COB	144,276.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	102		0	63,452.70		10,160.00
ROUTINE NURSERY	3		0	1,650.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	105		0	65,102.70		10,160.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	957.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	957.00		0.00
TOTAL ACCOMODATIONS	106		0	66,059.70		10,160.00

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,080.65	0.00	OTHER LAB	960.91	0.00
MED/SURG SUPPLY	18,787.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,231.87	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,255.62	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,141.61	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	217.73	0.00	MRI SERVICES	5,277.47	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,658.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	32,667.44	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,493.88	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,438.09	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,770.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,973.87	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,083.21	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,437.61	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	150.00	0.00	IMPL DEV CHARGE PATIENTS	541.29	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,288.86	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,851.20	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,501.71	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	872.45	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,510.70	0.00			
			TOTAL ANCILLARY	260,192.50	0.00
			TOTAL ACCOMODATIONS	66,059.70	10,160.00
			TOTAL CHARGES	326,252.20	10,160.00

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: 09/24/2013  
Run Time: 17:03:55  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,534,352.36	ADJUSTMENTS	949,361.57
COVERED CHARGES	13,141,897.17	CONTRACTUAL ALLOW	10,230,181.97
NON-COVERD CHARGES	1,392,455.19	TOTAL MEDICAID LIAB	2,911,715.20
		LESS: COB	12,149.38
		LESS: COPAYMENT	9,130.48
		REIMBURSEMENT	2,890,435.34
		ALL OTHER	2,412,448.70
		FEE SCHEDULE-LAB	256,353.49
		INJECTABLE DRUGS	221,633.15

TOTAL NUMBER OF CLAIMS 7,294

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181,951.30	2,003.91	OTHER LAB	259,347.26	0.00
MED/SURG SUPPLY	350,838.05	5,000.19	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	4,229.56	290.63
RADIOLOGY-DIAGNOSTIC	864,965.44	7,474.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,177,294.63	213,715.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,701.63	11,068.22	FEE SCHEDULE LAB	2,341,109.35	515,406.02
EKG/ECG	199,215.32	10,233.31	MRI SERVICES	392,662.27	15,602.14
IV THERAPY	5,177.32	87.29	PROFESSIONAL FEES	0.00	147.50
OPERATING ROOM	1,489,766.17	156,553.26	DURABLE MED. EQUIP.	0.00	118.53
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	20,694.31	227.41
RESPIRATORY SERVICES	57,367.89	17,273.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	142,871.97	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,068,558.75	88,034.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	338,458.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	686,550.22	194,996.27
RADIOLOGY THERAPEUTIC	19,028.36	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,069.09	4,812.72	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,815.34	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,987.03	2,534.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	24,750.00	150.00	IMPL DEV CHARGE PATIENTS	33,020.62	3,284.54
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	506,139.52	41,677.09			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,668.52	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	161,916.60	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	382,564.46	89,300.35			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,133.05	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	331,859.77	8,647.11			
			TOTAL ANCILLARY	13,141,897.17	1,392,455.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,141,897.17	1,392,455.19



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

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

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	464,918.39	ADJUSTMENTS	0.00
COVERED CHARGES	331,743.34	CONTRACTUAL ALLOW	90,912.05
NON-COVERD CHARGES	133,175.05	TOTAL MEDICAID LIAB	240,831.29
		LESS: COB	240,555.07
		LESS: COPAYMENT	276.22
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 286

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,071.43	0.00	OTHER LAB	5,173.19	0.00
MED/SURG SUPPLY	11,649.15	100.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,729.74	267.97	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,400.99	58,829.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	383.72	41.17	FEE SCHEDULE LAB	75,757.22	14,118.59
EKG/ECG	3,483.68	0.00	MRI SERVICES	2,837.50	2,898.18
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	787.50
OPERATING ROOM	47,203.92	21,374.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,871.75	484.92	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,217.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,812.83	1,401.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,138.62	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,323.03	5,623.03
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	3,179.45	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	718.72	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	123.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	300.00	0.00	IMPL DEV CHARGE PATIENTS	248.88	837.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,528.58
OTHER IMAGING SERVICE	19,060.29	18,172.38			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	925.60	588.38			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,221.71	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,571.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,361.98	99.52			
			TOTAL ANCILLARY	331,743.34	133,175.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	331,743.34	133,175.05

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1112137001679	04/03/12 - 04/03/12	05/21/12	0.00	3,528.58	0.00	4,670.96	0.00
TOTAL				0.00	3,528.58	0.00	4,670.96	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: 09/24/2013  
Run Time: 17:06:26  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	492,886.88	ADJUSTMENTS	3,482.61
COVERED CHARGES	470,751.06	CONTRACTUAL ALLOW	432,812.21
NON-COVERD CHARGES	22,135.82	TOTAL MEDICAID LIAB	37,938.85
		LESS: COB	47.40
		LESS: COPAYMENT	1,248.12
		REIMBURSEMENT	36,643.33
		TOTAL NUMBER OF CLAIMS	679

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER  
 1601 WATSON BLVD  
 WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER  
 000000976A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,573.80	0.00	OTHER LAB	4,979.12	0.00
MED/SURG SUPPLY	1,397.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,268.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,033.45	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	87,580.05	14,872.50
EKG/ECG	7,402.82	217.73	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,458.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,225.06	371.88	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	270,167.94	2,113.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	216.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,007.43	2,325.28
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	165.04	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	900.00	150.00	IMPL DEV CHARGE PATIENTS	0.00	465.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,266.08	1,453.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,274.80	0.00			
			TOTAL ANCILLARY	470,751.06	22,135.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	470,751.06	22,135.82

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

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

Run Date: 09/24/2013  
Run Time: 17:06:37  
Page: 13

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,858.06	ADJUSTMENTS	0.00
COVERED CHARGES	16,653.92	CONTRACTUAL ALLOW	3,671.21
NON-COVERD CHARGES	6,204.14	TOTAL MEDICAID LIAB	12,982.71
		LESS: COB	12,961.71
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER  
 1601 WATSON BLVD  
 WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER  
 000000976A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,558.43	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,271.06	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,495.92	664.59
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	113.04	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	9,342.89	59.27	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	205.91	276.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	785.85	933.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,653.92	6,204.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,653.92	6,204.14

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	440,593.38	ADJUSTMENTS	34,738.34
COVERED CHARGES	408,285.70	CONTRACTUAL ALLOW	306,028.68
NON-COVERD CHARGES	32,307.68	TOTAL MEDICAID LIAB	102,257.02
		LESS: COB	0.00
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	101,894.02

TOTAL NUMBER OF CLAIMS 21



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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,300.25	23.14	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,689.80	508.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,523.84	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,602.67	7,864.51
EKG/ECG	2,830.49	870.92	MRI SERVICES	6,189.97	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	384.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,385.51	247.32	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,211.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	246,606.63	10,336.12
RADIOLOGY THERAPEUTIC	9,614.91	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,581.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	887.15	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,188.10	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	55,216.37	12,000.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,073.71	457.32			
			TOTAL ANCILLARY	408,285.70	32,307.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	408,285.70	32,307.68

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

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

Run Date: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

IRWIN COUNTY HOSPITAL  
 710 N IRWIN AVE  
 OCILLA,GA 31774-5011

PROVIDER NUMBER 000000987A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,840,486.13	ADJUSTMENTS	86,170.90
COVERED CHARGES	1,674,598.25	CONTRACTUAL ALLOW	748,399.46
NON-COVERD CHARGES	165,887.88	TOTAL MEDICAID LIAB	926,198.79
		LESS: COB	2,468.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	923,730.16

TOTAL NUMBER OF ADMISSIONS 284

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	515		0	206,325.00		126,750.00
ROUTINE NURSERY	200		0	88,075.00		30,915.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	715		0	294,400.00		157,665.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	1		0	1,850.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	1,850.00		0.00
TOTAL ACCOMODATIONS	716		0	296,250.00		157,665.00

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	240,225.60	0.00	OTHER LAB	4,546.79	0.00
MED/SURG SUPPLY	138,195.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	155,598.71	0.00	EDUCATION & TRAINING	1,882.65	0.00
RADIOLOGY-DIAGNOSTIC	9,074.47	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,360.00	158.40	SPECIAL CHARGES	100.00	0.00
PHYSICAL THERAPY	660.20	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,335.00	0.00	MRI SERVICES	5,855.00	0.00
IV THERAPY	11,334.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	395,423.17	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	191,040.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,832.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,989.62	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,827.00	0.00	SPECIAL SERVICES	0.00	1,200.00
RECOVERY ROOM	22,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,294.22	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	33.36	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,092.58	0.00			
BLOOD	0.00	2,454.48			
BLOOD STORAGE & PRO.	13,565.61	3,150.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,060.00	1,260.00			
CARDIOLOGY	11,572.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,000.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,050.00	0.00			
			TOTAL ANCILLARY	1,378,348.25	8,222.88
			TOTAL ACCOMODATIONS	296,250.00	157,665.00
			TOTAL CHARGES	1,674,598.25	165,887.88

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

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

Run Date: 09/24/2013  
Run Time: 17:07:00  
Page: 3

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 12/01/11 THROUGH 11/30/12  
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: 09/24/2013  
Run Time: 17:07:00  
Page: 4

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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,529,539.19	ADJUSTMENTS	158,627.58
COVERED CHARGES	2,366,246.37	CONTRACTUAL ALLOW	1,810,716.89
NON-COVERD CHARGES	163,292.82	TOTAL MEDICAID LIAB	555,529.48
		LESS: COB	1,462.28
		LESS: COPAYMENT	1,440.78
		REIMBURSEMENT	552,626.42
		ALL OTHER	506,440.52
		FEE SCHEDULE-LAB	43,629.22
		INJECTABLE DRUGS	2,556.68

TOTAL NUMBER OF CLAIMS 1,024

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113,466.68	331.31	OTHER LAB	7,695.16	1,050.00
MED/SURG SUPPLY	79,026.16	1,146.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	640.17	EDUCATION & TRAINING	0.00	1,990.23
RADIOLOGY-DIAGNOSTIC	47,476.98	472.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,379.50	22,264.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	253,698.99	72,126.08
EKG/ECG	29,374.00	4,611.00	MRI SERVICES	20,082.53	5,027.68
IV THERAPY	245,776.00	7,740.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,045,041.40	5,612.99	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,027.17	614.78	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,080.62	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	126,686.00	2,368.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,262.79	20,950.28
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	750.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	6,428.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	122.80
OTHER IMAGING SERVICE	83,351.35	5,887.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,227.24	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,534.80	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	33,275.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	96,584.00	2,634.00			
			TOTAL ANCILLARY	2,366,246.37	162,767.82
			TOTAL ACCOMODATIONS	0.00	525.00
			TOTAL CHARGES	2,366,246.37	163,292.82

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

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

Run Date: 09/24/2013  
Run Time: 17:07:00  
Page: 6

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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8721	2212354008268	11/22/12 - 11/22/12	12/24/12	0.00	22.80	0.00	0.00	0.00
9637	2212354008268	11/22/12 - 11/22/12	12/24/12	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	122.80	0.00	0.00	0.00



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

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

Run Date: 09/24/2013  
Run Time: 17:07:22  
Page: 7

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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	814.23	ADJUSTMENTS	0.00
COVERED CHARGES	804.48	CONTRACTUAL ALLOW	418.26
NON-COVERD CHARGES	9.75	TOTAL MEDICAID LIAB	386.22
		LESS: COB	383.22
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 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	360.98	9.75
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	439.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4.50	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	804.48	9.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	804.48	9.75

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: 09/24/2013  
Run Time: 17:07:22  
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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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	80,848.16	ADJUSTMENTS	320.64
COVERED CHARGES	76,486.50	CONTRACTUAL ALLOW	70,053.40
NON-COVERD CHARGES	4,361.66	TOTAL MEDICAID LIAB	6,433.10
		LESS: COB	0.00
		LESS: COPAYMENT	204.02
		REIMBURSEMENT	6,229.08
		TOTAL NUMBER OF CLAIMS	115

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,453.78	0.00	OTHER LAB	0.00	350.00
MED/SURG SUPPLY	699.12	40.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,717.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,626.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,115.79	2,485.40
EKG/ECG	477.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,084.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,527.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,000.00	250.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,071.86	89.36
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	604.00	546.90			
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	2,110.00	600.00			
			TOTAL ANCILLARY	76,486.50	4,361.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	76,486.50	4,361.66

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

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

Run Date: 09/24/2013  
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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	12/01/11	THROUGH	11/30/12
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: 09/24/2013  
Run Time: 17:07:26  
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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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,852.00	ADJUSTMENTS	4,983.02
COVERED CHARGES	51,401.11	CONTRACTUAL ALLOW	41,429.07
NON-COVERD CHARGES	450.89	TOTAL MEDICAID LIAB	9,972.04
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	9,963.04

TOTAL NUMBER OF CLAIMS 2

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,448.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,039.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	53.79
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,107.22	152.10
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	31,551.88	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	454.12	245.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	51,401.11	450.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,401.11	450.89

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

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

Run Date: 09/24/2013  
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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	12/01/11	THROUGH	11/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,362.00	ADJUSTMENTS	0.00
COVERED CHARGES	25,362.00	CONTRACTUAL ALLOW	9,237.64
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	16,124.36
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,124.36

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		0	4,023.25		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	4,023.25		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	372.50		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	372.50		0.00
TOTAL ACCOMODATIONS	12		0	4,395.75		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: 09/24/2013  
 Run Time: 17:07:33  
 Page: 2

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,074.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,147.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,328.06	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	804.97	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,639.53	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	349.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	302.91	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	460.86	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,342.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,486.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29.42	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,966.25	0.00
			TOTAL ACCOMODATIONS	4,395.75	0.00
			TOTAL CHARGES	25,362.00	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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 17:07:34  
Page: 4

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	380,980.99	ADJUSTMENTS	15,549.99
COVERED CHARGES	323,704.37	CONTRACTUAL ALLOW	152,371.07
NON-COVERD CHARGES	57,276.62	TOTAL MEDICAID LIAB	171,333.30
		LESS: COB	0.00
		LESS: COPAYMENT	678.00
		REIMBURSEMENT	170,655.30
		ALL OTHER	154,194.02
		FEE SCHEDULE-LAB	13,829.62
		INJECTABLE DRUGS	2,631.66

TOTAL NUMBER OF CLAIMS 650

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

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

Run Date: 09/24/2013  
 Run Time: 17:07:34  
 Page: 5

JASPER MEMORIAL HOSP  
 898 COLLEGE ST  
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,361.04	215.31	OTHER LAB	2,255.09	286.81
MED/SURG SUPPLY	5,822.05	862.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	18.76	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,015.25	104.79	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,508.94	12,691.89	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	121.66	0.00	FEE SCHEDULE LAB	110,984.09	29,605.92
EKG/ECG	4,621.91	504.85	MRI SERVICES	4,281.23	0.00
IV THERAPY	10,015.63	2,424.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,469.82	213.25	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	86,771.53	1,655.48	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,306.61	7,364.57
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,260.49	647.46	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,828.63	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	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	2,619.35	283.50			
			TOTAL ANCILLARY	323,704.37	57,276.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	323,704.37	57,276.62

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,092.47	ADJUSTMENTS	379.00
COVERED CHARGES	26,895.04	CONTRACTUAL ALLOW	23,295.04
NON-COVERD CHARGES	5,197.43	TOTAL MEDICAID LIAB	3,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	3,495.00
		TOTAL NUMBER OF CLAIMS	72

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144.51	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	210.29	128.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,137.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,084.16	2,166.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,701.52	2,042.11
EKG/ECG	605.82	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,029.25	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	151.74	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,764.20	534.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,038.85	326.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,895.04	5,197.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,895.04	5,197.43



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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JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,699,340.05	ADJUSTMENTS	13,845.18
COVERED CHARGES	1,681,908.25	CONTRACTUAL ALLOW	1,140,902.87
NON-COVERD CHARGES	17,431.80	TOTAL MEDICAID LIAB	541,005.38
		LESS: COB	12,004.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	529,000.46

TOTAL NUMBER OF ADMISSIONS 95

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	358		0	161,100.00		14,050.00
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	358		0	161,100.00		14,050.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	102		0	102,000.00		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	102		0	102,000.00		0.00
TOTAL ACCOMODATIONS	460		0	263,100.00		14,050.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	548,585.75	895.80	OTHER LAB	4,090.00	0.00
MED/SURG SUPPLY	257,360.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	209,371.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,770.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,954.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,880.00	0.00	MRI SERVICES	1,800.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,770.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	120,848.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,435.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,900.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,001.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,445.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,761.50	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	3,525.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,275.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	437.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,200.00	2,486.00			
			TOTAL ANCILLARY	1,418,808.25	3,381.80
			TOTAL ACCOMODATIONS	263,100.00	14,050.00
			TOTAL CHARGES	1,681,908.25	17,431.80

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

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

Run Date: 09/24/2013  
Run Time: 17:07:58  
Page: 3

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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 17:07:58  
Page: 4

JEFF DAVIS HOSPITAL  
163 S TALLAHASSEE ST  
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,149,975.02	ADJUSTMENTS	23,598.77
COVERED CHARGES	1,031,180.82	CONTRACTUAL ALLOW	725,872.60
NON-COVERD CHARGES	118,794.20	TOTAL MEDICAID LIAB	305,308.22
		LESS: COB	8.01
		LESS: COPAYMENT	1,173.00
		REIMBURSEMENT	304,127.21
		ALL OTHER	269,148.42
		FEE SCHEDULE-LAB	33,742.37
		INJECTABLE DRUGS	1,236.42
		TOTAL NUMBER OF CLAIMS	1,216

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

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

Run Date: 09/24/2013  
 Run Time: 17:07:58  
 Page: 5

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,778.32	1,126.20	OTHER LAB	24,300.00	0.00
MED/SURG SUPPLY	79,872.00	181.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	20.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,396.00	3,111.00	OTHER THERAPEUTIC SVC	0.00	68.00
CT SCAN	195,374.00	18,006.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	273,761.00	73,729.00
EKG/ECG	12,992.00	1,008.00	MRI SERVICES	18,000.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,830.00	578.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,541.00	438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,144.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	165,336.00	2,105.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,970.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,617.50	17,346.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,400.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,372.00	780.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,875.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,200.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,311.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,111.00	298.00			
			TOTAL ANCILLARY	1,031,180.82	118,794.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,031,180.82	118,794.20



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

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL  
163 S TALLAHASSEE ST  
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,246.60	ADJUSTMENTS	0.00
COVERED CHARGES	12,163.00	CONTRACTUAL ALLOW	4,453.49
NON-COVERD CHARGES	3,083.60	TOTAL MEDICAID LIAB	7,709.51
		LESS: COB	7,702.42
		LESS: COPAYMENT	7.09
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,251.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	767.00	10.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	668.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,200.00	1,403.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,936.00	1,441.00
EKG/ECG	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	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	2,263.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56.00	229.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,200.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,163.00	3,083.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,163.00	3,083.60

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,109.80	ADJUSTMENTS	893.00
COVERED CHARGES	98,054.80	CONTRACTUAL ALLOW	87,384.30
NON-COVERD CHARGES	4,055.00	TOTAL MEDICAID LIAB	10,670.50
		LESS: COB	888.50
		LESS: COPAYMENT	357.04
		REIMBURSEMENT	9,424.96
		TOTAL NUMBER OF CLAIMS	196

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,070.80	30.00	OTHER LAB	730.00	0.00
MED/SURG SUPPLY	3,197.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,887.00	1,261.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,191.00	1,403.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,647.00	861.00
EKG/ECG	224.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,302.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,282.00	229.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,549.00	271.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	437.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	538.00	0.00			
			TOTAL ANCILLARY	98,054.80	4,055.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	98,054.80	4,055.00

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	588.00	ADJUSTMENTS	0.00
COVERED CHARGES	588.00	CONTRACTUAL ALLOW	332.87
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	255.13
		LESS: COB	255.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	102.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	260.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	588.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	588.00	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

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	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	324,197.50	ADJUSTMENTS	9,819.68
COVERED CHARGES	323,151.50	CONTRACTUAL ALLOW	2,449.69
NON-COVERD CHARGES	1,046.00	TOTAL MEDICAID LIAB	320,701.81
		LESS: COB	2,754.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	317,947.58

TOTAL NUMBER OF ADMISSIONS 53

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	172		0	68,800.00		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	172		0	68,800.00		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	172		0	68,800.00		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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,356.00	0.00	OTHER LAB	816.00	0.00
MED/SURG SUPPLY	35,093.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	67,192.00	0.00	EDUCATION & TRAINING	660.00	0.00
RADIOLOGY-DIAGNOSTIC	8,293.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,575.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	116.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,494.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,959.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,933.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,530.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	484.00	0.00			
BLOOD	744.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,046.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	106.50	0.00			
			TOTAL ANCILLARY	254,351.50	1,046.00
			TOTAL ACCOMODATIONS	68,800.00	0.00
			TOTAL CHARGES	323,151.50	1,046.00

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

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

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 17:08:42  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	857,522.48	ADJUSTMENTS	31,032.41
COVERED CHARGES	764,190.58	CONTRACTUAL ALLOW	487,895.29
NON-COVERD CHARGES	93,331.90	TOTAL MEDICAID LIAB	276,295.29
		LESS: COB	111.00
		LESS: COPAYMENT	1,914.00
		REIMBURSEMENT	274,270.29
		ALL OTHER	229,405.64
		FEE SCHEDULE-LAB	42,244.65
		INJECTABLE DRUGS	2,620.00
		TOTAL NUMBER OF CLAIMS	1,669

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

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

Run Date: 09/24/2013  
 Run Time: 17:08:42  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,187.00	4,456.00	OTHER LAB	12,811.00	0.00
MED/SURG SUPPLY	67,151.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	17.00	EDUCATION & TRAINING	0.00	180.00
RADIOLOGY-DIAGNOSTIC	45,960.00	3,077.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,616.00	2,018.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,649.00	66.00	FEE SCHEDULE LAB	191,736.00	48,189.90
EKG/ECG	22,079.00	3,496.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,358.00	7,196.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,082.00	3,648.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,784.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	187,629.00	10,193.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,348.00	8,679.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,921.00	770.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,164.00	996.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,748.00	350.00			
BLOOD	496.00	0.00			
BLOOD STORAGE & PRO.	523.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,566.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,382.18	0.00			
			TOTAL ANCILLARY	764,190.58	93,331.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	764,190.58	93,331.90

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

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,019.00	ADJUSTMENTS	0.00
COVERED CHARGES	951.00	CONTRACTUAL ALLOW	596.20
NON-COVERD CHARGES	68.00	TOTAL MEDICAID LIAB	354.80
		LESS: COB	354.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 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	26.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	395.00	68.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	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	162.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	308.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	951.00	68.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	951.00	68.00

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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JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	108,988.00	ADJUSTMENTS	320.64
COVERED CHARGES	103,078.00	CONTRACTUAL ALLOW	91,610.30
NON-COVERD CHARGES	5,910.00	TOTAL MEDICAID LIAB	11,467.70
		LESS: COB	19.24
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	11,115.46
		TOTAL NUMBER OF CLAIMS	205



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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,855.00	860.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,171.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,520.00	446.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,462.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,619.00	1,838.00
EKG/ECG	3,835.00	308.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,883.00	387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,959.00	1,013.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,210.00	1,058.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	83.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	481.00	0.00			
			TOTAL ANCILLARY	103,078.00	5,910.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	103,078.00	5,910.00

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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JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

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

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

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

\*\* NO DATA \*\*

\*\* END 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

JENKINS COUNTY HOSPITAL  
 931 E WINTHROPE AVE  
 MILLEN,GA 30442-1839

PROVIDER NUMBER 000001042A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,131.07	ADJUSTMENTS	0.00
COVERED CHARGES	48,140.92	CONTRACTUAL ALLOW	14,545.22
NON-COVERD CHARGES	14,990.15	TOTAL MEDICAID LIAB	33,595.70
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	33,595.70

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	4,796.00		1,383.25
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	8		0	4,796.00		1,383.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	8		0	4,796.00		1,383.25

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL  
 931 E WINTHROPE AVE  
 MILLEN,GA 30442-1839

PROVIDER NUMBER  
 000001042A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,480.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,344.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,753.37	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,908.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,295.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	862.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	479.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	11,628.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	231.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,476.40	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	707.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,203.20	1,978.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,422.05	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	3,182.30	0.00			
			TOTAL ANCILLARY	43,344.92	13,606.90
			TOTAL ACCOMODATIONS	4,796.00	1,383.25
			TOTAL CHARGES	48,140.92	14,990.15

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 17:09:24  
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JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,129,422.57	ADJUSTMENTS	15,144.63
COVERED CHARGES	948,738.67	CONTRACTUAL ALLOW	640,283.87
NON-COVERD CHARGES	180,683.90	TOTAL MEDICAID LIAB	308,454.80
		LESS: COB	229.55
		LESS: COPAYMENT	666.00
		REIMBURSEMENT	307,559.25
		ALL OTHER	286,444.38
		FEE SCHEDULE-LAB	21,114.87
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 800



JENKINS COUNTY HOSPITAL  
 931 E WINTHROPE AVE  
 MILLEN,GA 30442-1839

PROVIDER NUMBER  
 000001042A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,021.64	7,509.45	OTHER LAB	83,648.10	1,500.00
MED/SURG SUPPLY	15,761.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,702.35	1,771.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,509.80	16,352.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118.00	250.00	FEE SCHEDULE LAB	227,956.62	68,064.15
EKG/ECG	12,214.15	344.90	MRI SERVICES	0.00	0.00
IV THERAPY	4,028.75	1,913.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	222,464.00	76,092.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,581.00	1,650.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	168,000.81	1,137.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,956.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,745.60	1,970.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	20,314.30	2,127.35			
			TOTAL ANCILLARY	948,738.67	180,683.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	948,738.67	180,683.90

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

JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,556.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,435.05	CONTRACTUAL ALLOW	129.05
NON-COVERD CHARGES	120.95	TOTAL MEDICAID LIAB	1,306.00
		LESS: COB	1,306.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

JENKINS COUNTY HOSPITAL  
 931 E WINTHROPE AVE  
 MILLEN,GA 30442-1839

PROVIDER NUMBER  
 000001042A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115.40	105.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	45.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	347.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	99.00	15.95
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	794.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,435.05	120.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,435.05	120.95

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

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

Run Date: 09/24/2013  
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JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,675.30	ADJUSTMENTS	144.00
COVERED CHARGES	110,593.65	CONTRACTUAL ALLOW	100,143.65
NON-COVERD CHARGES	4,081.65	TOTAL MEDICAID LIAB	10,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	375.00
		REIMBURSEMENT	10,075.00
		TOTAL NUMBER OF CLAIMS	209

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL  
 931 E WINTHROPE AVE  
 MILLEN,GA 30442-1839

PROVIDER NUMBER  
 000001042A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,267.85	1,037.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,313.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,350.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,190.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,098.30	2,943.75
EKG/ECG	1,207.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	442.25	100.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	67,105.50	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	487.60	0.00			
			TOTAL ANCILLARY	110,593.65	4,081.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	110,593.65	4,081.65

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

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

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

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

-----CHARGES-----		-----PAYMENTS-----		
TOTAL CHARGES	880.40	ADJUSTMENTS	0.00	
COVERED CHARGES	880.40	CONTRACTUAL ALLOW	524.06	
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	356.34	
		LESS: COB	353.34	
		LESS: COPAYMENT	3.00	
		REIMBURSEMENT	0.00	
			TOTAL NUMBER OF CLAIMS	2

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

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSPITAL  
 931 E WINTHROPE AVE  
 MILLEN,GA 30442-1839

PROVIDER NUMBER  
 000001042A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148.90	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	190.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	540.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	880.40	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	880.40	0.00

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

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

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

JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	279,973.01	ADJUSTMENTS	4,363.02
COVERED CHARGES	277,144.81	CONTRACTUAL ALLOW	189,824.41
NON-COVERD CHARGES	2,828.20	TOTAL MEDICAID LIAB	87,320.40
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	87,269.40
		TOTAL NUMBER OF CLAIMS	20



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

JENKINS COUNTY HOSPITAL  
 931 E WINTHROPE AVE  
 MILLEN,GA 30442-1839

PROVIDER NUMBER  
 000001042A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,590.55	137.10	OTHER LAB	16,400.00	0.00
MED/SURG SUPPLY	3,355.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	538.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,390.00	1,695.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,008.70	996.10
EKG/ECG	344.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	217,458.56	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,100.00	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	4,958.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	277,144.81	2,828.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	277,144.81	2,828.20

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

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

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

GWINNETT MEDICAL CENTER-DULUTH  
 3620 HOWELL FERRY RD  
 DULUTH,GA 30096-3178

PROVIDER NUMBER 000001064A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,455,480.75	ADJUSTMENTS	454,000.35
COVERED CHARGES	9,986,878.75	CONTRACTUAL ALLOW	5,883,829.35
NON-COVERD CHARGES	468,602.00	TOTAL MEDICAID LIAB	4,103,049.40
		LESS: COB	67,485.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,035,563.53

TOTAL NUMBER OF ADMISSIONS 451

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,531		0	1,346,080.00		124,862.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,531		0	1,346,080.00		124,862.00
SPECIAL CARE SERVICES						
CCU	1		0	3,900.00		0.00
ICU	610		0	1,027,574.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	611		0	1,031,474.00		0.00
TOTAL ACCOMODATIONS	2,142		0	2,377,554.00		124,862.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	821,805.00	763.00	OTHER LAB	108,371.00	0.00
MED/SURG SUPPLY	69,588.00	6,440.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,062,776.75	0.00	EDUCATION & TRAINING	6,002.00	140.00
RADIOLOGY-DIAGNOSTIC	412,154.00	0.00	OTHER THERAPEUTIC SVC	0.00	780.00
CT SCAN	807,498.00	27,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,923.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	134,636.00	0.00	MRI SERVICES	146,414.00	0.00
IV THERAPY	10,937.00	4,155.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	853,663.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	285,705.00	958.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	166,023.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	96,733.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	898,098.00	3,058.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	115,751.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	79,261.00	0.00	INJECTABLE DRUGS	690,982.00	0.00
RADIOLOGY THERAPEUTIC	943.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,620.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,240.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,000.00	278,800.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	218,207.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,830.00
OTHER IMAGING SERVICE	105,025.00	6,546.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	84,028.00	10,070.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	123,401.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	239,089.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,738.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,713.00	0.00			
			TOTAL ANCILLARY	7,609,324.75	343,740.00
			TOTAL ACCOMODATIONS	2,377,554.00	124,862.00
			TOTAL CHARGES	9,986,878.75	468,602.00

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: 09/24/2013  
Run Time: 17:09:59  
Page: 3

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012214058060	04/05/12 - 04/08/12	08/06/12	0.00	2,205.00	0.00	0.00	0.00
615	2312299000066	03/06/12 - 03/15/12	12/03/12	0.00	2,625.00	0.00	0.00	0.00
TOTAL				0.00	4,830.00	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: 09/24/2013  
Run Time: 17:10:15  
Page: 4

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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 17:10:15  
Page: 5

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,623,188.80	ADJUSTMENTS	162,611.47
COVERED CHARGES	5,724,658.70	CONTRACTUAL ALLOW	4,572,070.07
NON-COVERD CHARGES	1,898,530.10	TOTAL MEDICAID LIAB	1,152,588.63
		LESS: COB	0.00
		LESS: COPAYMENT	2,862.81
		REIMBURSEMENT	1,149,725.82
		ALL OTHER	1,045,640.14
		FEE SCHEDULE-LAB	90,440.38
		INJECTABLE DRUGS	13,645.30
		TOTAL NUMBER OF CLAIMS	2,621

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219,730.00	778.00	OTHER LAB	60,039.00	19,210.00
MED/SURG SUPPLY	23,434.00	12,482.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	136.00	EDUCATION & TRAINING	0.00	218.00
RADIOLOGY-DIAGNOSTIC	446,703.00	31,880.00	OTHER THERAPEUTIC SVC	0.00	6,110.00
CT SCAN	532,842.00	525,341.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	401.00	2,012.00	FEE SCHEDULE LAB	883,185.70	94,186.10
EKG/ECG	117,566.00	819.00	MRI SERVICES	279,730.00	105,605.00
IV THERAPY	91,844.00	6,527.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	179,572.00	618,627.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,889.00	15,969.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	174,125.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	115,520.00	36,069.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,656,369.00	31,027.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	154,288.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	141,156.00	181,280.00
RADIOLOGY THERAPEUTIC	3,045.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	478.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	153.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,000.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89.00	500.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,130.00	0.00	IMPL DEV CHARGE PATIENTS	27,457.00	77,494.00
LITHOTRIPSY	20,000.00	0.00	NO CC/INVALID REV CODE	0.00	2,625.00
OTHER IMAGING SERVICE	315,804.00	17,092.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,254.00	38,629.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	118,652.00	37,168.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50,432.00	20,302.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	55,402.00	2,783.00			
			TOTAL ANCILLARY	5,724,658.70	1,898,500.10
			TOTAL ACCOMODATIONS	0.00	30.00
			TOTAL CHARGES	5,724,658.70	1,898,530.10



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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212198007467	06/11/12 - 06/11/12	07/23/12	0.00	2,625.00	0.00	0.00	0.00
TOTAL				0.00	2,625.00	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: 09/24/2013  
Run Time: 17:11:17  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINNETT MEDICAL CENTER-DULUTH  
3620 HOWELL FERRY RD  
DULUTH,GA 30096-3178

PROVIDER NUMBER  
000001064A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,511.00	ADJUSTMENTS	0.00
COVERED CHARGES	28,466.00	CONTRACTUAL ALLOW	16,848.99
NON-COVERD CHARGES	14,045.00	TOTAL MEDICAID LIAB	11,617.01
		LESS: COB	11,608.01
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,797.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	75.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,291.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,570.00	1,066.00
EKG/ECG	1,092.00	0.00	MRI SERVICES	0.00	3,971.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	6,286.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60.00	60.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,972.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,265.00	176.00	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	244.00	746.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	216.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,512.00	555.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	969.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,466.00	14,045.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,466.00	14,045.00

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: 09/24/2013  
Run Time: 17:11:18  
Page: 10

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	368,843.00	ADJUSTMENTS	379.57
COVERED CHARGES	326,582.00	CONTRACTUAL ALLOW	310,303.46
NON-COVERD CHARGES	42,261.00	TOTAL MEDICAID LIAB	16,278.54
		LESS: COB	0.00
		LESS: COPAYMENT	429.03
		REIMBURSEMENT	15,849.51
		TOTAL NUMBER OF CLAIMS	291

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,469.00	0.00	OTHER LAB	5,099.00	1,130.00
MED/SURG SUPPLY	492.00	1,130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	140.00
RADIOLOGY-DIAGNOSTIC	34,818.00	422.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,266.00	23,548.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	45,167.00	5,052.00
EKG/ECG	6,006.00	0.00	MRI SERVICES	0.00	3,971.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	380.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	178,349.00	1,159.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,359.00	3,415.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,163.00	1,914.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	326,582.00	42,261.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	326,582.00	42,261.00

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: 09/24/2013  
Run Time: 17:11:23  
Page: 12

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,899.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,625.00	CONTRACTUAL ALLOW	1,622.00
NON-COVERD CHARGES	2,274.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	331.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,274.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	65.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,229.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,625.00	2,274.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,625.00	2,274.00

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: 09/24/2013  
Run Time: 17:11:24  
Page: 14

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,471.00	ADJUSTMENTS	5,735.29
COVERED CHARGES	64,846.00	CONTRACTUAL ALLOW	53,351.42
NON-COVERD CHARGES	10,625.00	TOTAL MEDICAID LIAB	11,494.58
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	11,482.58
		TOTAL NUMBER OF CLAIMS	2



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

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

Run Date: 09/24/2013  
 Run Time: 17:11:24  
 Page: 15

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,788.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	81.00	37.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	664.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	297.00	FEE SCHEDULE LAB	2,992.00	71.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,260.00	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	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,841.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,210.00	218.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	800.00	10,000.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,178.00	0.00			
			TOTAL ANCILLARY	64,846.00	10,625.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,846.00	10,625.00

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GWINNETT MEDICAL CENTER-DULUTH  
3620 HOWELL FERRY RD  
DULUTH,GA 30096-3178

PROVIDER NUMBER  
000001064A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER 000001075A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,419,297.81	ADJUSTMENTS	203,251.60
COVERED CHARGES	5,324,676.69	CONTRACTUAL ALLOW	3,141,809.92
NON-COVERD CHARGES	94,621.12	TOTAL MEDICAID LIAB	2,182,866.77
		LESS: COB	21,721.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,161,145.37

TOTAL NUMBER OF ADMISSIONS 325

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	346		0	236,318.00		329.00
ROUTINE NURSERY	123		0	59,353.00		2,914.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	469		0	295,671.00		3,243.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	684		0	579,906.00		0.00
NICU	12		0	18,024.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	696		0	597,930.00		0.00
TOTAL ACCOMODATIONS	1,165		0	893,601.00		3,243.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,184,014.32	980.49	OTHER LAB	19,529.24	0.00
MED/SURG SUPPLY	271,958.61	494.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,003,283.23	4,149.56	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102,741.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	88,473.20	70,530.23	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,330.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	61,359.36	0.00	MRI SERVICES	66,161.76	0.00
IV THERAPY	164,716.28	2,536.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	244,585.17	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	97,840.64	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	616,776.32	3,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,144.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,019.92	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,006.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,109.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,366.00	99.00	INJECTABLE DRUGS	12,015.30	0.00
RADIOLOGY THERAPEUTIC	6,559.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,278.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	762.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	178.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,685.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,260.84
OTHER IMAGING SERVICE	29,788.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,909.60	697.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,717.52	2,547.00			
AUDIOLOGY	2,484.00	0.00			
CARDIOLOGY	78,498.14	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,408.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,137.34	2,679.00			
			TOTAL ANCILLARY	4,431,075.69	91,378.12
			TOTAL ACCOMODATIONS	893,601.00	3,243.00
			TOTAL CHARGES	5,324,676.69	94,621.12

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: 09/24/2013  
Run Time: 17:11:33  
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HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9112121010982	01/05/12 - 01/11/12	05/21/12	0.00	2,260.84	0.00	1,148.44	0.00
TOTAL				0.00	2,260.84	0.00	1,148.44	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: 09/24/2013  
 Run Time: 17:11:43  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	141,246.21	ADJUSTMENTS	0.00
COVERED CHARGES	138,422.49	CONTRACTUAL ALLOW	76,142.53
NON-COVERD CHARGES	2,823.72	TOTAL MEDICAID LIAB	62,279.96
		LESS: COB	62,279.96
		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	18		0	12,294.00		0.00
ROUTINE NURSERY	2		0	830.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	20		0	13,124.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	8		0	10,080.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8		0	10,080.00		0.00
TOTAL ACCOMODATIONS	28		0	23,204.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,753.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,607.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,181.24	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,732.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,434.76	2,568.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,345.60	0.00	MRI SERVICES	2,260.84	0.00
IV THERAPY	2,949.48	0.00	PROFESSIONAL FEES	0.00	255.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,193.36	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	660.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,441.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,499.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	217.00	0.00	INJECTABLE DRUGS	45,800.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	54.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	115,218.49	2,823.72
			TOTAL ACCOMODATIONS	23,204.00	0.00
			TOTAL CHARGES	138,422.49	2,823.72

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

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

Run Date: 09/24/2013  
Run Time: 17:11:45  
Page: 6

HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,653,303.75	ADJUSTMENTS	340,252.56
COVERED CHARGES	9,628,387.18	CONTRACTUAL ALLOW	7,700,365.71
NON-COVERD CHARGES	1,024,916.57	TOTAL MEDICAID LIAB	1,928,021.47
		LESS: COB	3,177.53
		LESS: COPAYMENT	9,702.31
		REIMBURSEMENT	1,915,141.63
		ALL OTHER	1,429,106.96
		FEE SCHEDULE-LAB	234,312.36
		INJECTABLE DRUGS	251,722.31

TOTAL NUMBER OF CLAIMS 6,140



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

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

Run Date: 09/24/2013  
 Run Time: 17:11:45  
 Page: 7

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	823,247.05	3,611.16	OTHER LAB	133,853.88	7,138.00
MED/SURG SUPPLY	336,365.32	5,650.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	882.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	390,915.72	6,315.48	OTHER THERAPEUTIC SVC	0.00	942.00
CT SCAN	489,882.62	13,573.02	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,927.00	11,641.00	FEE SCHEDULE LAB	1,822,300.26	456,283.20
EKG/ECG	151,918.24	5,920.64	MRI SERVICES	64,643.32	2,260.84
IV THERAPY	617,556.86	117,139.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	302,422.89	49,858.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,379.00	7,597.84	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,747.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,455.64	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	932,115.58	17,761.49	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,995.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,606,455.82	209,570.20
RADIOLOGY THERAPEUTIC	790,583.48	2,291.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,464.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,207.00	209.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	153,130.72	11,813.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,976.25	10,909.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	465.59
OTHER IMAGING SERVICE	102,864.16	11,102.36			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,521.80	10,551.28			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	168,275.40	46,799.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	161,593.80	517.00			
AMBULATORY SURGERY	79,196.76	11,572.92			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,224.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	121,167.21	2,540.08			
			TOTAL ANCILLARY	9,628,387.18	1,024,916.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,628,387.18	1,024,916.57

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

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

Run Date: 09/24/2013  
Run Time: 17:11:45  
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HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
405	2212053003944	12/03/11 - 12/03/11	02/27/12	0.00	465.59	0.00	0.00	0.00
TOTAL				0.00	465.59	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

Run Date: 09/24/2013  
Run Time: 17:13:15  
Page: 9

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	238,371.03	ADJUSTMENTS	0.00
COVERED CHARGES	186,630.81	CONTRACTUAL ALLOW	145,525.15
NON-COVERD CHARGES	51,740.22	TOTAL MEDICAID LIAB	41,105.66
		LESS: COB	40,982.66
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 131

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

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,958.51	86.60	OTHER LAB	2,783.36	0.00
MED/SURG SUPPLY	12,072.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,776.04	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,888.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,989.88	1,877.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	809.00	448.00	FEE SCHEDULE LAB	50,418.16	16,802.04
EKG/ECG	4,575.04	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,294.40	1,273.68	PROFESSIONAL FEES	0.00	102.00
OPERATING ROOM	18,829.51	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	580.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,888.76	59.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,335.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	190.00	INJECTABLE DRUGS	12,162.80	24,174.85
RADIOLOGY THERAPEUTIC	8,108.66	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	641.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	296.98
OTHER IMAGING SERVICE	2,864.04	1,530.04			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,989.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,696.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,085.06	1,482.31			
			TOTAL ANCILLARY	186,630.81	51,740.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	186,630.81	51,740.22

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
100 GROSS CRESCENT CIR	000001075A	SERVICE DATES	10/01/11	THROUGH	09/30/12
FORT OGLETHORPE, GA 30742-3643		ADMISSION DATES	00/00/00	THROUGH	00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3008	2211355014274	11/16/11 - 11/16/11	12/26/11	0.00	74.26	0.00	709.82	0.00
3001	5212322052295	02/02/12 - 02/03/12	01/07/13	0.00	222.72	0.00	2,680.22	0.00
TOTAL				0.00	296.98	0.00	3,390.04	0.00

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

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

Run Date: 09/24/2013  
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HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	371,250.62	ADJUSTMENTS	1,944.82
COVERED CHARGES	335,045.19	CONTRACTUAL ALLOW	308,697.46
NON-COVERD CHARGES	36,205.43	TOTAL MEDICAID LIAB	26,347.73
		LESS: COB	0.00
		LESS: COPAYMENT	762.02
		REIMBURSEMENT	25,585.71
		TOTAL NUMBER OF CLAIMS	471

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,529.86	629.92	OTHER LAB	4,259.20	380.00
MED/SURG SUPPLY	2,521.00	620.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	113.68	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,629.60	53.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,590.21	1,144.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	123,536.43	27,573.39
EKG/ECG	3,498.56	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,335.44	1,213.24	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	624.24	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,080.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	116,118.22	1,462.83	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	419.04	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,407.95	2,741.45
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	273.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,931.84	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	984.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	579.60	0.00			
			TOTAL ANCILLARY	335,045.19	36,205.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	335,045.19	36,205.43

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: 09/24/2013  
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HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,681.42	ADJUSTMENTS	0.00
COVERED CHARGES	21,862.90	CONTRACTUAL ALLOW	19,811.76
NON-COVERD CHARGES	1,818.52	TOTAL MEDICAID LIAB	2,051.14
		LESS: COB	2,048.14
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5



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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE,GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	293.26	0.00	OTHER LAB	320.00	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	0.00	183.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,842.95	1,246.88
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	518.04	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	335.24	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,699.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,261.10	53.40
RADIOLOGY THERAPEUTIC	708.76	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	159.72	0.00			
			TOTAL ANCILLARY	21,862.90	1,818.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,862.90	1,818.52

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	937,085.85	ADJUSTMENTS	25,936.40
COVERED CHARGES	934,140.56	CONTRACTUAL ALLOW	749,553.34
NON-COVERD CHARGES	2,945.29	TOTAL MEDICAID LIAB	184,587.22
		LESS: COB	0.00
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	184,425.22

TOTAL NUMBER OF CLAIMS 36

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

HUTCHESON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
100 GROSS CRESCENT CIR	000001075A	SERVICE DATES	10/01/11	THROUGH	09/30/12
FORT OGLETHORPE,GA 30742-3643		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,356.29	0.00	OTHER LAB	3,561.32	161.00
MED/SURG SUPPLY	12,756.67	8.00	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	5,700.08	726.20
EKG/ECG	269.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,203.16	1,124.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,767.85	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,179.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	465.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	640.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	742,286.20	440.05
RADIOLOGY THERAPEUTIC	80,604.45	486.04	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,861.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	1,547.64	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	575.55	0.00			
			TOTAL ANCILLARY	934,140.56	2,945.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	934,140.56	2,945.29

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

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

Run Date: 09/24/2013  
Run Time: 17:13:28  
Page: 18

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:13:36  
 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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,504,180.32	ADJUSTMENTS	213,056.04
COVERED CHARGES	14,381,327.85	CONTRACTUAL ALLOW	10,000,785.06
NON-COVERD CHARGES	122,852.47	TOTAL MEDICAID LIAB	4,380,542.79
		LESS: COB	41,300.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,339,242.12

TOTAL NUMBER OF ADMISSIONS 796

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,423		0	1,148,105.00		19,905.00
ROUTINE NURSERY	404		0	318,435.00		6,157.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,827		0	1,466,540.00		26,062.00
SPECIAL CARE SERVICES						
CCU	321		0	441,070.00		0.00
ICU	230		0	460,000.00		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	551		0	901,070.00		0.00
TOTAL ACCOMODATIONS	2,378		0	2,367,610.00		26,062.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	810,802.59	74.95	OTHER LAB	104,945.00	0.00
MED/SURG SUPPLY	684,711.07	1,973.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,763,396.22	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	225,589.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	725,105.97	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,324.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	213,987.25	0.00	MRI SERVICES	161,942.67	0.00
IV THERAPY	13,029.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,147,779.30	743.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	646,937.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	513,586.29	1,269.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	283,882.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	702,638.50	1,818.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	262,538.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	69,173.00	0.00	INJECTABLE DRUGS	1,250,524.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,475.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,538.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,180.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,857.00	4,295.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	333,394.35	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	21,804.76
OTHER IMAGING SERVICE	114,951.50	6,070.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	176,515.03	50,784.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	94,473.97	7,956.75			
AUDIOLOGY	90,480.00	0.00			
CARDIOLOGY	524,029.44	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	6,929.37	0.00			
			TOTAL ANCILLARY	12,013,717.85	96,790.47
			TOTAL ACCOMODATIONS	2,367,610.00	26,062.00
			TOTAL CHARGES	14,381,327.85	122,852.47

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2011287121399	09/20/11 - 09/22/11	10/24/11	0.00	2,220.25	0.00	0.00	0.00
615	2012012000260	10/27/11 - 11/02/11	01/16/12	0.00	2,220.25	0.00	0.00	0.00
615	2012016024026	07/09/11 - 07/10/11	01/23/12	0.00	2,036.38	0.00	0.00	0.00
615	2012034070669	01/07/12 - 01/12/12	02/13/12	0.00	2,220.25	0.00	0.00	0.00
615	2212082013371	01/04/12 - 01/10/12	03/26/12	0.00	2,220.25	0.00	0.00	0.00
615	2012130078886	12/06/11 - 12/07/11	05/14/12	0.00	2,220.25	0.00	0.00	0.00
615	2012131069553	03/29/12 - 04/07/12	05/14/12	0.00	2,190.25	0.00	0.00	0.00
615	2012163030691	04/29/12 - 05/03/12	06/18/12	0.00	2,220.25	0.00	0.00	0.00
615	2012178062251	05/17/12 - 05/19/12	07/02/12	0.00	2,220.25	0.00	0.00	0.00
615	2013067149447	07/05/11 - 07/07/11	03/18/13	0.00	2,036.38	0.00	0.00	0.00
TOTAL				0.00	21,804.76	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: 09/24/2013  
 Run Time: 17:14:05  
 Page: 4

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,339.60	ADJUSTMENTS	0.00
COVERED CHARGES	44,339.60	CONTRACTUAL ALLOW	14,455.82
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	29,883.78
		LESS: COB	29,883.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6		0	4,440.00		0.00
ROUTINE NURSERY	6		0	4,725.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	9,165.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		0	9,165.00		0.00



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,591.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,717.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,170.50	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	13,828.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,585.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,431.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,456.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	288.00	0.00	INJECTABLE DRUGS	2,478.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	940.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	321.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,365.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	35,174.60	0.00
			TOTAL ACCOMODATIONS	9,165.00	0.00
			TOTAL CHARGES	44,339.60	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: 09/24/2013  
Run Time: 17:14:08  
Page: 6

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,831,770.61	ADJUSTMENTS	366,458.28
COVERED CHARGES	12,220,129.32	CONTRACTUAL ALLOW	9,799,025.80
NON-COVERD CHARGES	1,611,641.29	TOTAL MEDICAID LIAB	2,421,103.52
		LESS: COB	2,976.97
		LESS: COPAYMENT	10,472.76
		REIMBURSEMENT	2,407,653.79
		ALL OTHER	2,137,852.61
		FEE SCHEDULE-LAB	207,565.51
		INJECTABLE DRUGS	62,235.67

TOTAL NUMBER OF CLAIMS 6,026

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,788.67	2,311.36	OTHER LAB	90,713.75	11,285.25
MED/SURG SUPPLY	296,945.50	44,283.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	111.43	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	608,785.88	24,265.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,449,622.76	53,947.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,931.00	13,951.25	FEE SCHEDULE LAB	2,033,496.13	423,140.66
EKG/ECG	119,513.50	1,494.00	MRI SERVICES	699,589.01	13,031.57
IV THERAPY	241,548.75	1,514.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,783,925.75	343,659.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	181,049.56	169,229.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	253,577.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,818,291.25	33,407.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,504.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	288.00	INJECTABLE DRUGS	575,181.42	153,707.55
RADIOLOGY THERAPEUTIC	2,530.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,116.25	3,559.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,941.25	1,683.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	337,306.13	39,610.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,842.92	54,690.49
LITHOTRIPSY	52,320.00	17,440.00	NO CC/INVALID REV CODE	0.00	8,637.13
OTHER IMAGING SERVICE	457,302.99	19,300.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	44,934.07	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	198,595.94	89,794.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	205,348.11	77,506.50			
AMBULATORY SURGERY	7,415.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	319,852.83	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68,159.50	9,790.75			
			TOTAL ANCILLARY	12,220,129.32	1,611,641.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,220,129.32	1,611,641.29

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: 09/24/2013  
Run Time: 17:14:08  
Page: 8

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2011222075203	07/06/11 - 07/06/11	08/15/11	0.00	2,036.38	0.00	0.00	0.00
615	2011299038913	10/04/11 - 10/04/11	10/31/11	0.00	2,190.25	0.00	0.00	0.00
615	2012003063252	12/09/11 - 12/09/11	01/09/12	0.00	2,190.25	0.00	0.00	0.00
615	2012101054787	03/22/12 - 03/22/12	04/16/12	0.00	2,220.25	0.00	0.00	0.00
TOTAL				0.00	8,637.13	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: 09/24/2013  
Run Time: 17:16:16  
Page: 9

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,393.94	ADJUSTMENTS	0.00
COVERED CHARGES	46,195.53	CONTRACTUAL ALLOW	16,462.57
NON-COVERD CHARGES	25,198.41	TOTAL MEDICAID LIAB	29,732.96
		LESS: COB	29,666.96
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	328.35	0.00	OTHER LAB	1,124.75	0.00
MED/SURG SUPPLY	1,884.87	100.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,446.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,958.50	10,761.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,280.00	296.00	FEE SCHEDULE LAB	6,270.00	509.00
EKG/ECG	249.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	388.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,458.25	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	13,365.50	160.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	861.31	721.68
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	4,015.50	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	4,060.00	668.25			
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	11,981.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,409.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	95.00	0.00			
			TOTAL ANCILLARY	46,195.53	25,198.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,195.53	25,198.41

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: 09/24/2013  
Run Time: 17:16:19  
Page: 11

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	955,369.23	ADJUSTMENTS	3,775.85
COVERED CHARGES	917,956.29	CONTRACTUAL ALLOW	875,106.31
NON-COVERD CHARGES	37,412.94	TOTAL MEDICAID LIAB	42,849.98
		LESS: COB	48.85
		LESS: COPAYMENT	1,557.18
		REIMBURSEMENT	41,243.95
		TOTAL NUMBER OF CLAIMS	766

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,647.63	0.00	OTHER LAB	2,031.25	819.75
MED/SURG SUPPLY	7,751.43	6.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,577.25	307.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,742.90	2,004.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	173,667.89	22,221.00
EKG/ECG	10,419.00	0.00	MRI SERVICES	8,404.44	0.00
IV THERAPY	3,126.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,515.00	390.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	494,369.50	2,600.50	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	31,116.93	4,991.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	133.25	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	18,302.75	4,071.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,150.82	0.00			
			TOTAL ANCILLARY	917,956.29	37,412.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	917,956.29	37,412.94



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: 09/24/2013  
Run Time: 17:16:33  
Page: 13

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,896.26	ADJUSTMENTS	0.00
COVERED CHARGES	4,705.56	CONTRACTUAL ALLOW	2,045.47
NON-COVERD CHARGES	190.70	TOTAL MEDICAID LIAB	2,660.09
		LESS: COB	2,654.09
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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

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

Run Date: 09/24/2013  
 Run Time: 17:16:33  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER  
 1 MEADOWS PKWY  
 VIDALIA,GA 30474-8759

PROVIDER NUMBER  
 000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	76.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	943.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,222.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,331.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	133.00	190.70
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	4,705.56	190.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,705.56	190.70

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

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,038,181.51	ADJUSTMENTS	61,570.44
COVERED CHARGES	980,322.20	CONTRACTUAL ALLOW	815,782.36
NON-COVERD CHARGES	57,859.31	TOTAL MEDICAID LIAB	164,539.84
		LESS: COB	0.00
		LESS: COPAYMENT	285.00
		REIMBURSEMENT	164,254.84
		TOTAL NUMBER OF CLAIMS	32

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,338.41	854.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	65,156.95	1,822.93	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,901.25	12,317.11	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,823.74	2,555.00
EKG/ECG	249.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,401.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	456,101.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	175,005.96	2,064.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,797.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,581.00	163.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,652.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,134.03	20,218.49
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	22,072.33	5,119.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,970.92	10,100.73
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	694.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,482.58	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,959.23	2,643.75			
			TOTAL ANCILLARY	980,322.20	57,859.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	980,322.20	57,859.31

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: 09/24/2013  
Run Time: 17:16:38  
Page: 17

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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER 000001108A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,229,682.09	ADJUSTMENTS	1,697,431.79
COVERED CHARGES	11,827,620.59	CONTRACTUAL ALLOW	8,413,541.79
NON-COVERD CHARGES	402,061.50	TOTAL MEDICAID LIAB	3,414,078.80
		LESS: COB	31,993.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,382,085.39

TOTAL NUMBER OF ADMISSIONS 590

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,325		0	1,137,034.00		184,876.00
ROUTINE NURSERY	528		0	523,642.00		95,163.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,853		0	1,660,676.00		280,039.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	227		0	711,191.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	227		0	711,191.00		0.00
TOTAL ACCOMODATIONS	2,080		0	2,371,867.00		280,039.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER 000001108A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494,577.20	4,696.00	OTHER LAB	25,434.00	0.00
MED/SURG SUPPLY	515,260.00	12,179.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,695,060.79	7,613.00	EDUCATION & TRAINING	390.00	0.00
RADIOLOGY-DIAGNOSTIC	174,098.00	0.00	OTHER THERAPEUTIC SVC	0.00	4,164.00
CT SCAN	318,657.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,066.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	61,920.00	0.00	MRI SERVICES	200,391.00	0.00
IV THERAPY	29,595.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	684,510.00	34,390.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	626,047.00	2,371.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	719,286.00	2,977.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,448.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	273,388.00	3,840.00	SPECIAL SERVICES	0.00	4,857.00
RECOVERY ROOM	74,459.00	729.00	DRUG-SPECIFIC/HOME IV	0.00	6,959.00
LABORATORY PATHOLOGIC	56,047.00	0.00	INJECTABLE DRUGS	2,494,097.60	14,624.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,875.00	3,783.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	27,076.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	53,732.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,629.00	0.00
LITHOTRIPSY	18,296.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	85,885.00	5,767.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	149,475.00	8,994.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,741.00	3,234.00			
AUDIOLOGY	43,953.00	0.00			
CARDIOLOGY	278,386.00	845.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,208.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,766.00	0.00			
			TOTAL ANCILLARY	9,455,753.59	122,022.50
			TOTAL ACCOMODATIONS	2,371,867.00	280,039.00
			TOTAL CHARGES	11,827,620.59	402,061.50

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER 000001108A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	106,410.50	ADJUSTMENTS	0.00
COVERED CHARGES	101,148.50	CONTRACTUAL ALLOW	59,510.39
NON-COVERD CHARGES	5,262.00	TOTAL MEDICAID LIAB	41,638.11
		LESS: COB	41,638.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	22		0	19,296.00		4,073.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	22		0	19,296.00		4,073.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	19,296.00		4,073.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER  
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,085.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,023.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,476.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,454.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,583.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,226.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	1,189.00
RECOVERY ROOM	2,187.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	405.00	0.00	INJECTABLE DRUGS	15,745.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
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	966.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	81,852.50	1,189.00
			TOTAL ACCOMODATIONS	19,296.00	4,073.00
			TOTAL CHARGES	101,148.50	5,262.00

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: 09/24/2013  
Run Time: 17:17:04  
Page: 5

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,737,421.92	ADJUSTMENTS	536,578.34
COVERED CHARGES	9,605,922.32	CONTRACTUAL ALLOW	7,796,867.94
NON-COVERD CHARGES	1,131,499.60	TOTAL MEDICAID LIAB	1,809,054.38
		LESS: COB	6,229.79
		LESS: COPAYMENT	2,243.40
		REIMBURSEMENT	1,800,581.19
		ALL OTHER	1,621,149.73
		FEE SCHEDULE-LAB	90,446.67
		INJECTABLE DRUGS	88,984.79

TOTAL NUMBER OF CLAIMS 2,858

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER  
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	466,244.00	20,956.00	OTHER LAB	85,950.00	0.00
MED/SURG SUPPLY	356,596.50	20,264.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	337,747.00	7,981.00	OTHER THERAPEUTIC SVC	0.00	24,236.00
CT SCAN	1,083,584.00	68,110.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,512.00	7,381.00	FEE SCHEDULE LAB	1,428,583.32	280,796.70
EKG/ECG	104,232.00	2,064.00	MRI SERVICES	153,005.00	16,058.00
IV THERAPY	273,504.00	74,236.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	483,317.50	86,367.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	56,621.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,405.00	2,436.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	149,734.00	5,606.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,177,442.00	74,923.00	SPECIAL SERVICES	0.00	159.00
RECOVERY ROOM	172,863.00	3,673.00	DRUG-SPECIFIC/HOME IV	0.00	997.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	884,499.00	261,310.40
RADIOLOGY THERAPEUTIC	216,989.00	34,156.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,119.00	4,737.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,398.00	2,908.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,919.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	270.00	1,080.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,384.00	17,372.00
LITHOTRIPSY	54,888.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	454,346.00	33,564.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	86,904.00	5,996.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	143,547.00	20,769.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	144,025.00	51,444.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	604.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	179,609.00	0.00			
			TOTAL ANCILLARY	9,605,922.32	1,131,499.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,605,922.32	1,131,499.60

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

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	200,225.00	ADJUSTMENTS	0.00
COVERED CHARGES	155,989.50	CONTRACTUAL ALLOW	80,894.34
NON-COVERD CHARGES	44,235.50	TOTAL MEDICAID LIAB	75,095.16
		LESS: COB	75,059.16
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 55

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

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER  
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,321.00	141.50	OTHER LAB	1,702.00	0.00
MED/SURG SUPPLY	10,587.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,007.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,763.00	14,330.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,387.00	3,739.00
EKG/ECG	1,032.00	0.00	MRI SERVICES	3,425.00	0.00
IV THERAPY	8,501.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,350.00	2,408.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,676.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	148.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,422.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,990.00	1,116.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,592.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,699.50	19,693.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,607.00	2,808.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,780.00	0.00			
			TOTAL ANCILLARY	155,989.50	44,235.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	155,989.50	44,235.50

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: 09/24/2013  
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NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	575,722.50	ADJUSTMENTS	1,409.44
COVERED CHARGES	544,337.50	CONTRACTUAL ALLOW	518,493.23
NON-COVERD CHARGES	31,385.00	TOTAL MEDICAID LIAB	25,844.27
		LESS: COB	0.00
		LESS: COPAYMENT	660.01
		REIMBURSEMENT	25,184.26
		TOTAL NUMBER OF CLAIMS	462

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER  
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,779.50	62.00	OTHER LAB	1,980.00	0.00
MED/SURG SUPPLY	2,415.00	108.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,079.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,364.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	107,301.00	19,174.00
EKG/ECG	8,514.00	0.00	MRI SERVICES	4,211.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,553.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	872.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,628.00	148.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	303,599.00	3,952.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	583.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,752.00	7,941.00
RADIOLOGY THERAPEUTIC	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,709.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	440.00	0.00			
			TOTAL ANCILLARY	544,337.50	31,385.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	544,337.50	31,385.00

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,976.50	ADJUSTMENTS	0.00
COVERED CHARGES	21,660.50	CONTRACTUAL ALLOW	15,634.07
NON-COVERD CHARGES	2,316.00	TOTAL MEDICAID LIAB	6,026.43
		LESS: COB	6,014.43
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12



SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER 000001108A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	514.50	14.00	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	804.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,151.00	1,486.00
EKG/ECG	516.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,568.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	124.00	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,895.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,660.50	2,316.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,660.50	2,316.00

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

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,959,503.60	ADJUSTMENTS	150,148.80
COVERED CHARGES	1,847,791.10	CONTRACTUAL ALLOW	1,572,565.30
NON-COVERD CHARGES	111,712.50	TOTAL MEDICAID LIAB	275,225.80
		LESS: COB	0.00
		LESS: COPAYMENT	492.55
		REIMBURSEMENT	274,733.25
		TOTAL NUMBER OF CLAIMS	55

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

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER  
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,270.50	297.00	OTHER LAB	2,966.00	0.00
MED/SURG SUPPLY	105,813.50	1.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,676.00	1,893.00	OTHER THERAPEUTIC SVC	0.00	2,190.00
CT SCAN	88,791.00	2,073.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	338.00	FEE SCHEDULE LAB	41,924.60	8,979.50
EKG/ECG	3,870.00	516.00	MRI SERVICES	0.00	0.00
IV THERAPY	67,965.00	1,140.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	111,966.00	2,660.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,016.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,658.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,139.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,656.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	820,507.50	56,613.00
RADIOLOGY THERAPEUTIC	263,498.00	2,392.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	338.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	82,446.00	1,241.00
LITHOTRIPSY	18,296.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,998.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,478.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	85,041.00	31,041.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,725.00	0.00			
			TOTAL ANCILLARY	1,847,791.10	111,712.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,847,791.10	111,712.50

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

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:18:26  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER 000001119A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,107,155.16	ADJUSTMENTS	7,537,614.32
COVERED CHARGES	92,439,970.76	CONTRACTUAL ALLOW	66,507,013.89
NON-COVERD CHARGES	2,667,184.40	TOTAL MEDICAID LIAB	25,932,956.87
		LESS: COB	231,709.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	25,701,247.47

TOTAL NUMBER OF ADMISSIONS 3,121

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,098		19	6,884,460.00		358,062.00
ROUTINE NURSERY	1,875		0	731,973.00		45,597.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,973		19	7,616,433.00		403,659.00
SPECIAL CARE SERVICES						
CCU	3,608		1	5,019,253.00		205,159.00
ICU	2,046		0	4,501,047.00		0.00
NICU	1,393		0	3,425,774.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		300	0.00		403,200.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7,047		301	12,946,074.00		608,359.00
TOTAL ACCOMODATIONS	16,020		320	20,562,507.00		1,012,018.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,933,353.80	362,214.70	OTHER LAB	486,953.00	6,225.00
MED/SURG SUPPLY	3,310,040.82	106,346.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,051,109.16	104,488.00	EDUCATION & TRAINING	104,327.00	1,351.00
RADIOLOGY-DIAGNOSTIC	1,950,590.00	13,355.00	OTHER THERAPEUTIC SVC	0.00	18,494.00
CT SCAN	4,470,666.00	51,443.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	466,079.00	43,505.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	427,828.00	2,260.00	MRI SERVICES	1,537,851.00	9,868.00
IV THERAPY	681,835.00	59,798.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,879,954.50	68,446.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,441,511.00	9,997.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,177,764.50	70,784.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,371,516.00	9,924.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,463,096.00	11,603.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	843,155.00	10,753.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	423,935.00	1,824.00	INJECTABLE DRUGS	83,915.25	0.00
RADIOLOGY THERAPEUTIC	644,988.00	155,883.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	243,954.00	16,344.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	187,234.00	24,969.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	534,313.00	135,459.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,263.00	9,992.00	TRAUMA RESPONSE	0.00	16,720.00
PSYCHIATRIC SERVICES	1,059.00	10,794.00	IMPL DEV CHARGE PATIENTS	2,833,184.00	4,290.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	81,160.00
OTHER IMAGING SERVICE	488,871.00	15,896.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	788,501.00	167,665.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	482,697.00	29,118.00			
AUDIOLOGY	397,166.00	677.00			
CARDIOLOGY	2,838,268.00	20,607.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	103,647.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	214,838.73	2,913.00			
			TOTAL ANCILLARY	71,877,463.76	1,655,166.40
			TOTAL ACCOMODATIONS	20,562,507.00	1,012,018.00
			TOTAL CHARGES	92,439,970.76	2,667,184.40

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE I  
INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2211301019807	07/05/11 - 07/07/11	11/07/11	0.00	5,781.00	0.00	0.00	0.00
615	2012170034242	06/07/12 - 06/11/12	06/25/12	0.00	5,781.00	0.00	0.00	0.00
615	2012170034297	06/09/12 - 06/11/12	06/25/12	0.00	5,781.00	0.00	0.00	0.00
615	2012171056197	02/11/12 - 02/13/12	06/25/12	0.00	2,947.00	0.00	0.00	0.00
615	2012184040568	06/13/12 - 06/16/12	07/09/12	0.00	5,781.00	0.00	0.00	0.00
615	2012188051125	06/27/12 - 06/29/12	07/16/12	0.00	5,781.00	0.00	0.00	0.00
615	2012192054927	11/07/11 - 11/09/11	07/16/12	0.00	2,947.00	0.00	0.00	0.00
615	2012194083185	04/28/12 - 05/04/12	07/16/12	0.00	5,781.00	0.00	0.00	0.00
615	2012198026077	10/02/11 - 10/23/11	07/23/12	0.00	5,781.00	0.00	0.00	0.00
615	2012213045121	02/13/12 - 02/17/12	08/06/12	0.00	5,781.00	0.00	0.00	0.00
615	2312258000056	06/02/12 - 06/05/12	12/10/12	0.00	5,781.00	0.00	0.00	0.00
615	2012279059729	03/26/12 - 04/11/12	10/15/12	0.00	5,781.00	0.00	0.00	0.00
615	2212297002284	03/27/12 - 04/12/12	10/29/12	0.00	2,947.00	0.00	0.00	0.00
615	5213002000117	05/19/12 - 06/09/12	01/07/13	0.00	2,947.00	0.00	0.00	0.00
615	2013016054567	03/17/12 - 03/19/12	01/21/13	0.00	5,781.00	0.00	0.00	0.00
615	2013184101662	01/25/12 - 01/26/12	07/08/13	0.00	5,781.00	0.00	0.00	0.00
TOTAL				0.00	81,160.00	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER 000001119A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	674,313.50	ADJUSTMENTS	0.00
COVERED CHARGES	561,791.75	CONTRACTUAL ALLOW	129,738.05
NON-COVERD CHARGES	112,521.75	TOTAL MEDICAID LIAB	432,053.70
		LESS: COB	432,053.70
		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	50		0	50,700.00		360.00
ROUTINE NURSERY	10		0	5,373.00		1,890.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	60		0	56,073.00		2,250.00
SPECIAL CARE SERVICES						
CCU	27		0	37,854.00		0.00
ICU	26		0	47,957.00		0.00
NICU	44		0	105,440.00		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		11	0.00		14,784.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	97		11	191,251.00		14,784.00
TOTAL ACCOMODATIONS	157		11	247,324.00		17,034.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,355.25	35,300.75	OTHER LAB	671.00	0.00
MED/SURG SUPPLY	5,443.00	7,188.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,186.00	0.00	EDUCATION & TRAINING	2,870.00	0.00
RADIOLOGY-DIAGNOSTIC	3,985.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,139.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,332.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	66.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,344.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	44,702.00	26,607.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,534.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	5,882.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,419.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	336.00	1,052.00	INJECTABLE DRUGS	426.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	569.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	72.00	72.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	514.00	IMPL DEV CHARGE PATIENTS	0.00	9,331.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,795.00
OTHER IMAGING SERVICE	3,666.00	3,330.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,199.00	2,416.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,133.00	0.00			
CARDIOLOGY	2,351.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	314,467.75	95,487.75
			TOTAL ACCOMODATIONS	247,324.00	17,034.00
			TOTAL CHARGES	561,791.75	112,521.75

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

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

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	1111347004353	10/12/11 - 10/19/11	12/26/11	0.00	3,795.00	0.00	20,147.00	0.00
TOTAL				0.00	3,795.00	0.00	20,147.00	0.00

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

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

Run Date: 09/24/2013  
Run Time: 17:19:41  
Page: 7

KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,138,396.16	ADJUSTMENTS	1,186,861.04
COVERED CHARGES	29,201,007.24	CONTRACTUAL ALLOW	23,128,381.92
NON-COVERD CHARGES	3,937,388.92	TOTAL MEDICAID LIAB	6,072,625.32
		LESS: COB	61,047.16
		LESS: COPAYMENT	10,812.00
		REIMBURSEMENT	6,000,766.16
		ALL OTHER	5,168,170.92
		FEE SCHEDULE-LAB	458,477.54
		INJECTABLE DRUGS	374,117.70

TOTAL NUMBER OF CLAIMS 11,567

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,094,530.50	8,344.25	OTHER LAB	326,760.00	3,965.00
MED/SURG SUPPLY	510,064.00	7,323.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,273.34	EDUCATION & TRAINING	1,371.00	0.00
RADIOLOGY-DIAGNOSTIC	1,254,762.00	22,654.00	OTHER THERAPEUTIC SVC	0.00	167.00
CT SCAN	4,025,475.00	394,445.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,560.00	34,431.00	FEE SCHEDULE LAB	4,236,181.08	753,649.65
EKG/ECG	254,075.00	2,421.00	MRI SERVICES	1,362,360.00	148,249.00
IV THERAPY	1,094,480.00	2,023.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,626,316.00	288,184.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	221,461.00	0.00	REHAB THERAPY	0.00	150.00
RESPIRATORY SERVICES	194,628.00	37,502.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	528,850.00	9,789.00	AMBULANCE	0.00	0.00
GI SERVICES	1,363.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,879,844.00	10,072.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	335,115.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	206.00	INJECTABLE DRUGS	1,663,777.00	963,740.00
RADIOLOGY THERAPEUTIC	1,036,571.00	811,500.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,256.00	8,651.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,243.00	6,777.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,342.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	221,046.00	30,940.00	TRAUMA RESPONSE	0.00	16,120.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,568.00	5,794.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	132.00
OTHER IMAGING SERVICE	1,591,742.00	171,904.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	198,245.00	36,546.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	925,810.00	16,698.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	861,566.00	123,165.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,514.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	537,473.63	11,087.68			
			TOTAL ANCILLARY	29,201,007.24	3,937,244.92
			TOTAL ACCOMODATIONS	0.00	144.00
			TOTAL CHARGES	29,201,007.24	3,937,388.92

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

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

Run Date: 09/24/2013  
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KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8678	5911346000022	11/16/11 - 11/16/11	12/19/11	0.00	50.00	0.00	0.00	0.00
806	5911346000226	11/16/11 - 11/16/11	12/19/11	0.00	82.00	0.00	0.00	0.00
TOTAL				0.00	132.00	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: 09/24/2013  
Run Time: 17:22:27  
Page: 10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	839,365.85	ADJUSTMENTS	0.00
COVERED CHARGES	700,573.46	CONTRACTUAL ALLOW	165,954.70
NON-COVERD CHARGES	138,792.39	TOTAL MEDICAID LIAB	534,618.76
		LESS: COB	534,383.72
		LESS: COPAYMENT	235.04
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 290

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

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,228.00	87.25	OTHER LAB	12,793.00	1,806.00
MED/SURG SUPPLY	18,017.00	36.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	531.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,598.00	959.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,672.00	31,811.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,564.00	1,171.00	FEE SCHEDULE LAB	111,944.24	17,003.00
EKG/ECG	8,663.00	0.00	MRI SERVICES	11,324.00	8,697.00
IV THERAPY	38,971.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,960.00	19,130.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	45,131.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,011.00	809.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,494.00	36,982.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	158,939.00	1,296.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,637.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,429.75	5,695.00
RADIOLOGY THERAPEUTIC	829.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,008.00	800.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,637.00	144.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,131.00	2,940.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	246.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,337.00	7,295.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,772.00	833.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,018.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,497.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	995.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,727.47	767.14			
			TOTAL ANCILLARY	700,573.46	138,792.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	700,573.46	138,792.39

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

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

Run Date: 09/24/2013  
Run Time: 17:22:39  
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KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,408,175.62	ADJUSTMENTS	2,274.48
COVERED CHARGES	1,355,198.62	CONTRACTUAL ALLOW	1,300,062.25
NON-COVERD CHARGES	52,977.00	TOTAL MEDICAID LIAB	55,136.37
		LESS: COB	4,857.25
		LESS: COPAYMENT	1,383.00
		REIMBURSEMENT	48,896.12
		TOTAL NUMBER OF CLAIMS	899



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,804.00	360.00	OTHER LAB	39,382.00	2,709.00
MED/SURG SUPPLY	8,106.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,888.00	670.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	120,088.00	10,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	249.00	FEE SCHEDULE LAB	231,945.00	25,771.00
EKG/ECG	12,374.00	0.00	MRI SERVICES	34,297.00	0.00
IV THERAPY	73,339.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,305.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,526.00	1,018.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,309.00	424.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	627,732.00	320.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,024.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,773.00	249.00
RADIOLOGY THERAPEUTIC	3,533.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	410.00	303.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,608.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	57,785.00	10,422.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,970.62	0.00			
			TOTAL ANCILLARY	1,355,198.62	52,977.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,355,198.62	52,977.00

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

Run Date: 09/24/2013  
Run Time: 17:22:50  
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ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,073.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,318.00	CONTRACTUAL ALLOW	9,326.29
NON-COVERD CHARGES	3,755.00	TOTAL MEDICAID LIAB	22,991.71
		LESS: COB	22,964.71
		LESS: COPAYMENT	27.00

REIMBURSEMENT 0.00

TOTAL NUMBER OF CLAIMS 22

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

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

Run Date: 09/24/2013  
 Run Time: 17:22:50  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	521.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	97.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	54.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,318.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,244.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,596.00	892.00
EKG/ECG	807.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	947.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	865.00	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	15,765.00	87.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,040.00	478.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,318.00	3,755.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,318.00	3,755.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
Run Time: 17:22:55  
Page: 16

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,097,228.89	ADJUSTMENTS	311,193.02
COVERED CHARGES	6,360,213.04	CONTRACTUAL ALLOW	5,443,579.26
NON-COVERD CHARGES	737,015.85	TOTAL MEDICAID LIAB	916,633.78
		LESS: COB	0.00
		LESS: COPAYMENT	2,082.00
		REIMBURSEMENT	914,551.78

TOTAL NUMBER OF CLAIMS 179

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150,636.00	1,150.00	OTHER LAB	4,181.00	0.00
MED/SURG SUPPLY	184,987.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,850.00	8,015.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	118,993.00	2,512.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,039.00	2,036.00	FEE SCHEDULE LAB	88,780.30	15,140.60
EKG/ECG	11,621.00	807.00	MRI SERVICES	11,219.00	4,934.00
IV THERAPY	114,489.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	246,084.00	33,811.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,943.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	65,162.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,871.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,908.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,625,662.00	265,525.25
RADIOLOGY THERAPEUTIC	1,290,394.00	366,713.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,042.00	4,419.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,975.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,703.00	1,139.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	908,765.00	1,750.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	699.00	877.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,448.00	833.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,440.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	372,946.00	26,350.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,375.74	1,004.00			
			TOTAL ANCILLARY	6,360,213.04	737,015.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,360,213.04	737,015.85

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: 09/24/2013  
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Page: 18

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:23:13  
 Page: 1

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,625,902.54	ADJUSTMENTS	387,831.41
COVERED CHARGES	22,195,655.94	CONTRACTUAL ALLOW	16,871,750.08
NON-COVERD CHARGES	430,246.60	TOTAL MEDICAID LIAB	5,323,905.86
		LESS: COB	37,254.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,286,651.41

TOTAL NUMBER OF ADMISSIONS 754

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,056		0	1,772,226.00		60,926.00
ROUTINE NURSERY	141		0	86,402.00		2,560.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,197		0	1,858,628.00		63,486.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	528		1	1,130,986.00		2,170.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	528		1	1,130,986.00		2,170.00
TOTAL ACCOMODATIONS	2,725		1	2,989,614.00		65,656.00

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,301,297.32	0.00	OTHER LAB	110,001.50	0.00
MED/SURG SUPPLY	1,157,887.25	821.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,455,615.25	438.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	434,153.50	0.00	OTHER THERAPEUTIC SVC	0.00	1,192.00
CT SCAN	549,702.00	135,880.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,654.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	198,330.00	0.00	MRI SERVICES	109,519.00	0.00
IV THERAPY	25,038.00	374.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,114,984.50	3,876.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	317,727.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	809,537.25	2,093.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	194,490.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	96,339.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	667,064.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	169,018.50	577.00	DRUG-SPECIFIC/HOME IV	0.00	83,691.50
LABORATORY PATHOLOGIC	63,243.57	0.00	INJECTABLE DRUGS	4,305,567.10	35,109.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	29,653.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	20,410.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	104,295.00	18,699.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,076.00	52.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	647,735.42	0.00
LITHOTRIpsy	17,135.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	181,524.75	4,860.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	122,854.32	25,243.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	234,501.00	51,683.00			
AUDIOLOGY	360.00	0.00			
CARDIOLOGY	1,618,232.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,705.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,389.21	0.00			
			TOTAL ANCILLARY	19,206,041.94	364,590.60
			TOTAL ACCOMODATIONS	2,989,614.00	65,656.00
			TOTAL CHARGES	22,195,655.94	430,246.60



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:23:38  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER  
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	255,931.90	ADJUSTMENTS	0.00
COVERED CHARGES	250,981.65	CONTRACTUAL ALLOW	142,534.21
NON-COVERD CHARGES	4,950.25	TOTAL MEDICAID LIAB	108,447.44
		LESS: COB	108,447.44
		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	31		0	25,882.00		1,508.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	31		0	25,882.00		1,508.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	20,870.00		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	10		0	20,870.00		0.00
TOTAL ACCOMODATIONS	41		0	46,752.00		1,508.00

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,941.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,444.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,812.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,428.00	0.00	OTHER THERAPEUTIC SVC	0.00	138.00
CT SCAN	0.00	2,622.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	483.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,022.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	79.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,617.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	28,025.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,190.50	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	2,645.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,435.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	549.50	0.00	INJECTABLE DRUGS	41,911.47	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	367.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	48.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,467.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	515.04	682.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,818.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,097.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,082.00	0.00			
			TOTAL ANCILLARY	204,229.65	3,442.25
			TOTAL ACCOMODATIONS	46,752.00	1,508.00
			TOTAL CHARGES	250,981.65	4,950.25

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: 09/24/2013  
Run Time: 17:23:39  
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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,061,675.87	ADJUSTMENTS	293,915.32
COVERED CHARGES	12,693,792.59	CONTRACTUAL ALLOW	10,409,057.27
NON-COVERD CHARGES	1,367,883.28	TOTAL MEDICAID LIAB	2,284,735.32
		LESS: COB	2,320.24
		LESS: COPAYMENT	4,866.00
		REIMBURSEMENT	2,277,549.08
		ALL OTHER	2,076,187.41
		FEE SCHEDULE-LAB	166,919.76
		INJECTABLE DRUGS	34,441.91
		TOTAL NUMBER OF CLAIMS	4,886

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER  
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	388,116.15	149.75	OTHER LAB	102,545.75	5,182.50
MED/SURG SUPPLY	536,339.68	2,441.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	855,859.75	7,417.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,410,969.00	125,211.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,220.25	8,588.75	FEE SCHEDULE LAB	2,922,487.07	478,877.75
EKG/ECG	189,615.00	3,640.00	MRI SERVICES	279,324.00	18,620.00
IV THERAPY	137,976.00	10,633.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,194,302.46	200,358.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,560.00	9,207.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	86,315.00	515.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	281,839.00	3,915.00	AMBULANCE	0.00	0.00
GI SERVICES	151,395.93	25,987.07	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,970,377.50	14,055.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	171,466.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	448,308.55	244,670.86
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,015.25	4,688.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,631.00	2,985.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,293.00	1,413.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,811.20	54,963.30
LITHOTRIPSY	55,518.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	455,934.00	34,172.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,128.28	3,992.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	146,381.00	104,177.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	517,764.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	88,502.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	111,797.27	2,021.00			
			TOTAL ANCILLARY	12,693,792.59	1,367,883.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,693,792.59	1,367,883.28

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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Page: 7

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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	300,428.97	ADJUSTMENTS	0.00
COVERED CHARGES	211,996.27	CONTRACTUAL ALLOW	93,967.57
NON-COVERD CHARGES	88,432.70	TOTAL MEDICAID LIAB	118,028.70
		LESS: COB	117,971.70
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER  
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,776.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,736.25	401.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,061.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,440.00	22,365.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	62,028.75	6,416.75
EKG/ECG	3,451.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,631.00	138.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,966.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	1,464.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	824.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,285.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,017.00	2,368.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,823.00	1,207.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,476.58	43,730.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,595.00	423.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,652.75	5,914.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,060.16	2,628.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,096.00	1,376.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,969.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,707.00	0.00			
			TOTAL ANCILLARY	211,996.27	88,432.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	211,996.27	88,432.70

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: 09/24/2013  
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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	706,210.35	ADJUSTMENTS	1,176.66
COVERED CHARGES	666,143.42	CONTRACTUAL ALLOW	639,124.40
NON-COVERD CHARGES	40,066.93	TOTAL MEDICAID LIAB	27,019.02
		LESS: COB	0.00
		LESS: COPAYMENT	846.13
		REIMBURSEMENT	26,172.89

TOTAL NUMBER OF CLAIMS 483

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,905.81	351.08	OTHER LAB	1,283.00	0.00
MED/SURG SUPPLY	5,925.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,754.75	536.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,304.00	10,150.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	209,266.75	20,139.30
EKG/ECG	7,859.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,902.00	613.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,609.75	233.25	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	290,603.00	499.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,131.78	5,063.75
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	211.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,149.25	1,347.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,661.83	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,479.00	922.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,308.00	0.00			
			TOTAL ANCILLARY	666,143.42	40,066.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	666,143.42	40,066.93



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: 09/24/2013  
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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,197.39	ADJUSTMENTS	0.00
COVERED CHARGES	15,086.89	CONTRACTUAL ALLOW	11,958.54
NON-COVERD CHARGES	1,110.50	TOTAL MEDICAID LIAB	3,128.35
		LESS: COB	3,122.35
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143.29	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,789.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,328.50	208.25
EKG/ECG	337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	576.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,431.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	415.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	745.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,086.89	1,110.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,086.89	1,110.50

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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,428,699.83	ADJUSTMENTS	60,503.28
COVERED CHARGES	1,262,163.91	CONTRACTUAL ALLOW	1,065,411.25
NON-COVERD CHARGES	166,535.92	TOTAL MEDICAID LIAB	196,752.66
		LESS: COB	0.00
		LESS: COPAYMENT	140.74
		REIMBURSEMENT	196,611.92

TOTAL NUMBER OF CLAIMS 39

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,497.08	0.00	OTHER LAB	932.75	0.00
MED/SURG SUPPLY	270,924.42	1,129.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,700.75	403.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,025.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	483.75	FEE SCHEDULE LAB	44,671.75	4,586.25
EKG/ECG	3,869.00	728.00	MRI SERVICES	0.00	0.00
IV THERAPY	201.00	138.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	538,646.50	13,847.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49.25	626.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	134,684.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,098.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,651.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,483.91	40,994.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	483.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,531.50	99,285.80
LITHOTRIPSY	18,506.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,380.00	3,828.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	49,541.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,771.00	0.00			
			TOTAL ANCILLARY	1,262,163.91	166,535.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,262,163.91	166,535.92

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK HOSPITAL  
200 INDUSTRIAL BLVD  
DUBLIN,GA 31021-2981

PROVIDER NUMBER  
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,040.45	ADJUSTMENTS	0.00
COVERED CHARGES	23,040.45	CONTRACTUAL ALLOW	106.31
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	22,934.14
		LESS: COB	22,931.14
		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

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER  
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	958.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	396.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	2,349.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	830.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	18,506.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,040.45	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,040.45	0.00

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,178,088.64	ADJUSTMENTS	94,440.76
COVERED CHARGES	3,078,798.24	CONTRACTUAL ALLOW	2,244,841.90
NON-COVERD CHARGES	99,290.40	TOTAL MEDICAID LIAB	833,956.34
		LESS: COB	5,191.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	828,764.44

TOTAL NUMBER OF ADMISSIONS 143

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	517		4	463,831.00		91,532.40
ROUTINE NURSERY	61		0	28,324.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	578		4	492,155.00		91,532.40
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	41		0	62,402.00		0.00
NICU	1		0	945.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	42		0	63,347.00		0.00
TOTAL ACCOMODATIONS	620		4	555,502.00		91,532.40

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	687,156.40	0.00	OTHER LAB	12,399.00	0.00
MED/SURG SUPPLY	232,673.52	837.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	372,136.70	1,300.00	EDUCATION & TRAINING	4,788.00	0.00
RADIOLOGY-DIAGNOSTIC	31,734.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	161,857.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,806.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,914.30	0.00	MRI SERVICES	15,813.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	164,662.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,957.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	128,858.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,210.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	91,468.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,940.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,136.00	0.00	INJECTABLE DRUGS	471,961.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,687.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	107.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,063.00	0.00			
BLOOD	14,036.00	0.00			
BLOOD STORAGE & PRO.	7,801.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	270.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,194.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,146.93	4,141.00			
			TOTAL ANCILLARY	2,523,296.24	7,758.00
			TOTAL ACCOMODATIONS	555,502.00	91,532.40
			TOTAL CHARGES	3,078,798.24	99,290.40



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:25:32  
 Page: 3

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,984.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,717.00	CONTRACTUAL ALLOW	16,457.07
NON-COVERD CHARGES	267.00	TOTAL MEDICAID LIAB	16,259.93
		LESS: COB	16,259.93
		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	6,418.00		267.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	6,418.00		267.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	7		0	6,418.00		267.00

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,581.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,108.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,225.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,319.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,646.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	1,452.00	0.00			
BLOOD STORAGE & PRO.	968.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,299.00	0.00
			TOTAL ACCOMODATIONS	6,418.00	267.00
			TOTAL CHARGES	32,717.00	267.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 17:25:33  
Page: 5

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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,636,223.15	ADJUSTMENTS	199,834.09
COVERED CHARGES	4,064,048.82	CONTRACTUAL ALLOW	3,225,636.45
NON-COVERD CHARGES	572,174.33	TOTAL MEDICAID LIAB	838,412.37
		LESS: COB	8,559.74
		LESS: COPAYMENT	2,625.27
		REIMBURSEMENT	827,227.36
		ALL OTHER	723,862.17
		FEE SCHEDULE-LAB	101,227.49
		INJECTABLE DRUGS	2,137.70

TOTAL NUMBER OF CLAIMS 2,854

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,450.57	14,556.00	OTHER LAB	37,491.00	0.00
MED/SURG SUPPLY	147,351.12	350.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,511.00	EDUCATION & TRAINING	0.00	2,128.00
RADIOLOGY-DIAGNOSTIC	245,487.00	6,317.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	465,464.00	122,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,921.00	6,391.00	FEE SCHEDULE LAB	940,981.20	206,054.05
EKG/ECG	36,059.00	1,570.00	MRI SERVICES	77,255.00	11,158.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	248,336.66	24,131.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,597.00	622.00	REHAB THERAPY	390.00	5,340.00
RESPIRATORY SERVICES	38,835.00	6,622.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	918,867.50	28,758.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,620.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	94,908.00	43,267.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,304.00	1,604.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	11,533.00	0.00
LITHOTRIPSY	133.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	231,413.00	45,795.00			
BLOOD	8,712.00	0.00			
BLOOD STORAGE & PRO.	3,020.00	7,376.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,251.00	7,727.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50,120.00	2,049.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	168,548.77	25,976.94			
			TOTAL ANCILLARY	4,064,048.82	572,174.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,064,048.82	572,174.33

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 17:26:15  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER  
462 ELMA G MILES PKWY  
HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	119,035.51	ADJUSTMENTS	0.00
COVERED CHARGES	86,774.24	CONTRACTUAL ALLOW	57,073.20
NON-COVERD CHARGES	32,261.27	TOTAL MEDICAID LIAB	29,701.04
		LESS: COB	29,686.73
		LESS: COPAYMENT	14.31
		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

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,417.00	2,236.00	OTHER LAB	3,459.00	0.00
MED/SURG SUPPLY	2,725.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,636.00	EDUCATION & TRAINING	0.00	133.00
RADIOLOGY-DIAGNOSTIC	2,906.00	213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,215.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	537.00	1,131.00	FEE SCHEDULE LAB	23,462.00	5,236.00
EKG/ECG	931.00	133.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	98.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,662.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	311.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,051.00	138.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,640.00	643.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	540.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,719.00	1,065.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,593.00	4,794.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,082.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,739.24	4,387.27			
			TOTAL ANCILLARY	86,774.24	28,058.27
			TOTAL ACCOMODATIONS	0.00	4,203.00
			TOTAL CHARGES	86,774.24	32,261.27

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 17:26:17  
Page: 9

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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	429,564.79	ADJUSTMENTS	1,561.00
COVERED CHARGES	396,690.79	CONTRACTUAL ALLOW	373,139.79
NON-COVERD CHARGES	32,874.00	TOTAL MEDICAID LIAB	23,551.00
		LESS: COB	28.58
		LESS: COPAYMENT	456.01
		REIMBURSEMENT	23,066.41
		TOTAL NUMBER OF CLAIMS	472

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,077.00	565.00	OTHER LAB	799.00	0.00
MED/SURG SUPPLY	3,020.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,056.00	444.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,546.00	5,215.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	109,126.00	8,074.00
EKG/ECG	1,729.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	890.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	208,455.00	956.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,908.00	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,174.00	16,779.00			
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	910.79	0.00			
			TOTAL ANCILLARY	396,690.79	32,874.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	396,690.79	32,874.00



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,918.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,822.00	CONTRACTUAL ALLOW	9,988.91
NON-COVERD CHARGES	2,096.00	TOTAL MEDICAID LIAB	4,833.09
		LESS: COB	4,824.09
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 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	187.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	193.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,685.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,660.00	498.00
EKG/ECG	266.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,877.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	799.00	1,598.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,822.00	2,096.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,822.00	2,096.00

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

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 12/01/11 THROUGH 11/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	112,589.73	ADJUSTMENTS	13,667.79
COVERED CHARGES	109,351.14	CONTRACTUAL ALLOW	91,127.42
NON-COVERD CHARGES	3,238.59	TOTAL MEDICAID LIAB	18,223.72
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	18,214.72

TOTAL NUMBER OF CLAIMS 4

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 12/01/11 THROUGH 11/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,759.00	53.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,247.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,012.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,429.00	556.00
EKG/ECG	266.00	133.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,335.71	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	728.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,431.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,476.00	1,130.00
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	12,287.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	968.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,278.07	1,366.59			
			TOTAL ANCILLARY	109,351.14	3,238.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	109,351.14	3,238.59

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

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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	12/01/11	THROUGH	11/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER 000001163A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	209,355.25	ADJUSTMENTS	0.00
COVERED CHARGES	207,465.25	CONTRACTUAL ALLOW	131,016.97
NON-COVERD CHARGES	1,890.00	TOTAL MEDICAID LIAB	76,448.28
		LESS: COB	2,915.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	73,532.49
TOTAL NUMBER OF ADMISSIONS			16

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	92		0	36,064.00		1,890.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	92		0	36,064.00		1,890.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	92		0	36,064.00		1,890.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,822.75	0.00	OTHER LAB	838.75	0.00
MED/SURG SUPPLY	19,049.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,828.50	0.00	EDUCATION & TRAINING	57.75	0.00
RADIOLOGY-DIAGNOSTIC	3,197.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,400.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,170.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,506.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,024.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,556.25	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	6,762.00	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	2,325.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,249.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,046.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,948.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,973.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,644.50	0.00			
			TOTAL ANCILLARY	171,401.25	0.00
			TOTAL ACCOMODATIONS	36,064.00	1,890.00
			TOTAL CHARGES	207,465.25	1,890.00

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

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
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LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	638,923.55	ADJUSTMENTS	23,492.96
COVERED CHARGES	586,660.38	CONTRACTUAL ALLOW	320,823.48
NON-COVERD CHARGES	52,263.17	TOTAL MEDICAID LIAB	265,836.90
		LESS: COB	0.00
		LESS: COPAYMENT	1,161.00
		REIMBURSEMENT	264,675.90
		ALL OTHER	235,779.58
		FEE SCHEDULE-LAB	28,486.56
		INJECTABLE DRUGS	409.76

TOTAL NUMBER OF CLAIMS 912

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 17:26:31  
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LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,152.50	178.25	OTHER LAB	2,695.75	0.00
MED/SURG SUPPLY	16,039.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,583.50	740.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,052.00	6,871.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,044.75	623.25	FEE SCHEDULE LAB	130,364.24	35,226.17
EKG/ECG	10,198.25	453.00	MRI SERVICES	2,622.25	0.00
IV THERAPY	13,527.50	252.50	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	3,234.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	166,682.00	2,596.75	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	903.00	3,845.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	138.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,517.75	441.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,226.25	895.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,378.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,480.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,958.25	0.00			
			TOTAL ANCILLARY	586,660.38	52,263.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	586,660.38	52,263.17

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	158.75	ADJUSTMENTS	0.00
COVERED CHARGES	158.75	CONTRACTUAL ALLOW	144.05
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14.70
		LESS: COB	0.00
		LESS: COPAYMENT	14.70
		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  
 SUMMARY TYPE IV

Run Date: 09/24/2013  
 Run Time: 17:26:46  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	158.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	158.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	158.75	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 17:26:46  
Page: 8

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	87,393.25	ADJUSTMENTS	191.00
COVERED CHARGES	82,627.75	CONTRACTUAL ALLOW	75,677.75
NON-COVERD CHARGES	4,765.50	TOTAL MEDICAID LIAB	6,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	240.00
		REIMBURSEMENT	6,710.00
		TOTAL NUMBER OF CLAIMS	139

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,848.50	0.00	OTHER LAB	375.75	0.00
MED/SURG SUPPLY	1,403.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,075.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,722.75	1,154.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,964.00	2,419.25
EKG/ECG	1,057.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	757.50	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	223.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,015.75	184.50	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	114.00	1,007.25
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	441.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	628.25	0.00			
			TOTAL ANCILLARY	82,627.75	4,765.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	82,627.75	4,765.50

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: 09/24/2013  
Run Time: 17:26:48  
Page: 10

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
Run Time: 17:26:49  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,883.50	ADJUSTMENTS	0.00
COVERED CHARGES	9,663.00	CONTRACTUAL ALLOW	5,275.70
NON-COVERD CHARGES	1,220.50	TOTAL MEDICAID LIAB	4,387.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,387.30

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: 09/24/2013  
 Run Time: 17:26:49  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,064.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	577.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,009.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,596.75	545.50
EKG/ECG	755.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	386.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27.50	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	878.50	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	675.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,486.50	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	738.00	0.00			
			TOTAL ANCILLARY	9,663.00	1,220.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,663.00	1,220.50

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 17:26:49  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 521 HILL ST  
 THOMSON,GA 30824-0000

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	396,271.82	ADJUSTMENTS	9,898.92
COVERED CHARGES	392,580.92	CONTRACTUAL ALLOW	191,431.53
NON-COVERD CHARGES	3,690.90	TOTAL MEDICAID LIAB	201,149.39
		LESS: COB	124.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	201,025.02
			TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	76		0	42,712.00		1,686.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	76		0	42,712.00		1,686.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	76		0	42,712.00		1,686.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 521 HILL ST 000001185A SERVICE DATES 07/01/12 THROUGH 12/31/12  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,177.87	0.00	OTHER LAB	562.25	0.00
MED/SURG SUPPLY	45,596.40	2,004.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,935.55	0.00	EDUCATION & TRAINING	163.20	0.00
RADIOLOGY-DIAGNOSTIC	3,847.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,721.65	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,622.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	500.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,940.95	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,720.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,622.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,631.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,195.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,367.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	833.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	796.85	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	113,528.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,445.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,660.10	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	349,868.92	2,004.90
			TOTAL ACCOMODATIONS	42,712.00	1,686.00
			TOTAL CHARGES	392,580.92	3,690.90

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:27:21  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 17:27:22  
Page: 4

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,028,060.44	ADJUSTMENTS	156,964.17
COVERED CHARGES	907,520.93	CONTRACTUAL ALLOW	608,934.42
NON-COVERD CHARGES	120,539.51	TOTAL MEDICAID LIAB	298,586.51
		LESS: COB	90.00
		LESS: COPAYMENT	813.00
		REIMBURSEMENT	297,683.51
		ALL OTHER	278,666.30
		FEE SCHEDULE-LAB	14,777.06
		INJECTABLE DRUGS	4,240.15

TOTAL NUMBER OF CLAIMS 889

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 521 HILL ST  
 THOMSON,GA 30824-0000

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,516.80	0.00	OTHER LAB	3,382.40	0.00
MED/SURG SUPPLY	99,434.32	352.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	816.00
RADIOLOGY-DIAGNOSTIC	50,999.85	2,970.15	OTHER THERAPEUTIC SVC	0.00	9,662.50
CT SCAN	67,569.85	10,911.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	550.00	FEE SCHEDULE LAB	83,691.17	18,898.30
EKG/ECG	7,341.40	1,001.10	MRI SERVICES	0.00	0.00
IV THERAPY	41,103.00	13,238.85	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,660.83	20,175.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,060.40	5,352.15	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,988.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,320.00	1,260.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	229,407.50	1,267.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,955.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,744.91	20,456.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	669.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,055.55	8,993.90
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,895.00	536.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,890.50	3,153.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,591.35	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,889.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,022.70	273.90			
			TOTAL ANCILLARY	907,520.93	120,539.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	907,520.93	120,539.51

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,570.08	ADJUSTMENTS	0.00
COVERED CHARGES	13,728.94	CONTRACTUAL ALLOW	5,860.69
NON-COVERD CHARGES	1,841.14	TOTAL MEDICAID LIAB	7,868.25
		LESS: COB	7,859.25
		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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 521 HILL ST 000001185A SERVICE DATES 07/01/12 THROUGH 12/31/12  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	984.62	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,621.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	638.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,409.10	877.55
EKG/ECG	166.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,598.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,683.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52.65	482.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	201.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,248.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	282.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	842.47	480.84
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	0.00	0.00			
			TOTAL ANCILLARY	13,728.94	1,841.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,728.94	1,841.14

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: 09/24/2013  
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Page: 8

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,441.09	ADJUSTMENTS	1,238.62
COVERED CHARGES	41,353.92	CONTRACTUAL ALLOW	36,766.84
NON-COVERD CHARGES	3,087.17	TOTAL MEDICAID LIAB	4,587.08
		LESS: COB	0.00
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	4,455.08
		TOTAL NUMBER OF CLAIMS	82

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  
 521 HILL ST 000001185A SERVICE DATES 07/01/12 THROUGH 12/31/12  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,161.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,901.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,802.05	0.00	OTHER THERAPEUTIC SVC	0.00	773.00
CT SCAN	1,131.35	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,354.35	1,802.55
EKG/ECG	500.55	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,559.30	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52.65	52.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,745.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,720.11	458.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	424.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	41,353.92	3,087.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	41,353.92	3,087.17

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,054.37	ADJUSTMENTS	0.00
COVERED CHARGES	1,054.37	CONTRACTUAL ALLOW	631.90
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	422.47
		LESS: COB	422.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 521 HILL ST 000001185A SERVICE DATES 07/01/12 THROUGH 12/31/12  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	229.30	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	805.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,054.37	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,054.37	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 17:27:44  
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
521 HILL ST	000001185A	SERVICE DATES	07/01/12	THROUGH	12/31/12
THOMSON,GA 30824-0000		ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:26:55  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 521 HILL ST  
 THOMSON,GA 30824-0000

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	405,116.11	ADJUSTMENTS	13,935.13
COVERED CHARGES	402,006.21	CONTRACTUAL ALLOW	178,339.91
NON-COVERD CHARGES	3,109.90	TOTAL MEDICAID LIAB	223,666.30
		LESS: COB	734.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	222,932.03

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	90		0	47,700.00		2,878.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	90		0	47,700.00		2,878.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	4,542.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	4,542.00		0.00
TOTAL ACCOMODATIONS	93		0	52,242.00		2,878.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 521 HILL ST 000001185A SERVICE DATES 10/01/11 THROUGH 06/30/12  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,782.61	0.00	OTHER LAB	830.15	0.00
MED/SURG SUPPLY	45,160.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,172.55	0.00	EDUCATION & TRAINING	81.60	0.00
RADIOLOGY-DIAGNOSTIC	6,223.10	0.00	OTHER THERAPEUTIC SVC	0.00	231.90
CT SCAN	11,598.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,421.20	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,948.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,568.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,415.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,212.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,538.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,984.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,566.60	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	1,304.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	86,473.80	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.	2,890.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,591.35	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	349,764.21	231.90
			TOTAL ACCOMODATIONS	52,242.00	2,878.00
			TOTAL CHARGES	402,006.21	3,109.90

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:26:55  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 17:26:56  
Page: 4

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,298,537.69	ADJUSTMENTS	118,632.75
COVERED CHARGES	1,113,763.50	CONTRACTUAL ALLOW	800,530.93
NON-COVERD CHARGES	184,774.19	TOTAL MEDICAID LIAB	313,232.57
		LESS: COB	156.02
		LESS: COPAYMENT	1,191.00
		REIMBURSEMENT	311,885.55
		ALL OTHER	293,460.59
		FEE SCHEDULE-LAB	17,119.94
		INJECTABLE DRUGS	1,305.02

TOTAL NUMBER OF CLAIMS 1,179

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 521 HILL ST  
 THOMSON,GA 30824-0000

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,394.50	600.01	OTHER LAB	1,954.65	0.00
MED/SURG SUPPLY	134,020.10	511.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	100.00	EDUCATION & TRAINING	0.00	1,367.40
RADIOLOGY-DIAGNOSTIC	68,528.65	1,354.25	OTHER THERAPEUTIC SVC	0.00	16,907.35
CT SCAN	58,428.30	25,475.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	625.50	FEE SCHEDULE LAB	102,473.35	26,742.93
EKG/ECG	12,513.75	500.55	MRI SERVICES	0.00	0.00
IV THERAPY	48,056.65	8,485.50	PROFESSIONAL FEES	0.00	617.70
OPERATING ROOM	101,836.05	27,644.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,035.70	4,642.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,345.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	259,057.65	2,653.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,531.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,433.55	37,148.30
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	602.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,659.25	24,644.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,274.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,890.50	1,282.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,956.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,997.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,375.60	620.10			
			TOTAL ANCILLARY	1,113,763.50	182,526.19
			TOTAL ACCOMODATIONS	0.00	2,248.00
			TOTAL CHARGES	1,113,763.50	184,774.19

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,426.65	ADJUSTMENTS	0.00
COVERED CHARGES	3,823.55	CONTRACTUAL ALLOW	3,780.11
NON-COVERD CHARGES	3,603.10	TOTAL MEDICAID LIAB	43.44
		LESS: COB	34.44
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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  
 521 HILL ST 000001185A SERVICE DATES 10/01/11 THROUGH 06/30/12  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	44.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	638.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,400.60	3,581.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38.15	21.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	300.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	394.65	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	3,823.55	3,603.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,823.55	3,603.10

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: 09/24/2013  
Run Time: 17:27:12  
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UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,065.26	ADJUSTMENTS	370.58
COVERED CHARGES	71,820.91	CONTRACTUAL ALLOW	62,646.75
NON-COVERD CHARGES	6,244.35	TOTAL MEDICAID LIAB	9,174.16
		LESS: COB	0.00
		LESS: COPAYMENT	291.00
		REIMBURSEMENT	8,883.16
		TOTAL NUMBER OF CLAIMS	164

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  
 521 HILL ST 000001185A SERVICE DATES 10/01/11 THROUGH 06/30/12  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,499.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,064.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,984.45	0.00	OTHER THERAPEUTIC SVC	0.00	2,921.55
CT SCAN	2,262.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,626.10	1,259.55
EKG/ECG	166.85	166.85	MRI SERVICES	0.00	0.00
IV THERAPY	2,252.15	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	421.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,894.10	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	2,365.34	1,286.70
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	283.95	424.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	71,820.91	6,244.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	71,820.91	6,244.35



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  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	06/30/12
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	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
521 HILL ST	000001185A	SERVICE DATES	10/01/11	THROUGH	06/30/12
THOMSON,GA 30824-0000		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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
521 HILL ST	000001185A	SERVICE DATES	10/01/11	THROUGH	06/30/12
THOMSON,GA 30824-0000		ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,831,082.64	ADJUSTMENTS	4,168,876.61
COVERED CHARGES	47,983,503.90	CONTRACTUAL ALLOW	30,438,292.29
NON-COVERD CHARGES	847,578.74	TOTAL MEDICAID LIAB	17,545,211.61
		LESS: COB	131,743.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,413,467.78

TOTAL NUMBER OF ADMISSIONS 1,854

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,254		2	5,236,809.00		24,514.00
ROUTINE NURSERY	2,250		0	1,327,006.60		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10,504		2	6,563,815.60		24,514.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,140		0	1,610,577.00		0.00
NICU	325		0	461,175.00		0.00
PED ICU	22		0	30,431.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,487		0	2,102,183.00		0.00
TOTAL ACCOMODATIONS	11,991		2	8,665,998.60		24,514.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,921,585.51	45,114.90	OTHER LAB	283,519.76	712.98
MED/SURG SUPPLY	4,838,547.61	94,829.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,901,464.63	151,548.34	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	972,887.61	2,212.42	OTHER THERAPEUTIC SVC	0.00	14,462.00
CT SCAN	1,881,413.98	24,824.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	458,401.00	4,588.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	632,096.35	0.00	MRI SERVICES	820,979.96	0.00
IV THERAPY	164,388.30	5,453.88	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,132,406.00	27,867.40	DURABLE MED. EQUIP.	0.00	1,637.00
LABOR/DELIVERY ROOM	755,703.27	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,739,805.67	8,055.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	194,903.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,691.16	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,707,873.86	3,439.86	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	361,826.50	6,790.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	151,470.95	512.00	INJECTABLE DRUGS	4,783,523.39	19,971.80
RADIOLOGY THERAPEUTIC	206,403.20	1,501.81	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	125,860.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	93,356.91	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	290,067.00	41,681.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,592.58	24,749.25	TRAUMA RESPONSE	0.00	25,959.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,042,243.53	694.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	282,228.63	14,838.81			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,438,552.00	247,172.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	151,584.70	40,082.75			
AUDIOLOGY	59,553.66	11,462.39			
CARDIOLOGY	676,936.63	2,618.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	37,352.53	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	205,285.42	284.00			
			TOTAL ANCILLARY	39,317,505.30	823,064.74
			TOTAL ACCOMODATIONS	8,665,998.60	24,514.00
			TOTAL CHARGES	47,983,503.90	847,578.74

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:28:24  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	468,529.20	ADJUSTMENTS	0.00
COVERED CHARGES	468,529.20	CONTRACTUAL ALLOW	252,945.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	215,583.25
		LESS: COB	215,583.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	95		0	60,794.00		0.00
ROUTINE NURSERY	4		0	1,688.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	99		0	62,482.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,838.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	2,838.00		0.00
TOTAL ACCOMODATIONS	101		0	65,320.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,732.55	0.00	OTHER LAB	1,998.44	0.00
MED/SURG SUPPLY	47,164.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,382.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,456.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,266.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,487.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,909.50	0.00	MRI SERVICES	13,715.55	0.00
IV THERAPY	409.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,337.71	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,907.82	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,212.24	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,224.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,899.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,625.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	12,975.90	0.00	INJECTABLE DRUGS	25,933.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	598.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	736.17	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	48.26	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,254.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,606.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63,591.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	673.71	0.00			
CARDIOLOGY	4,710.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,354.00	0.00			
			TOTAL ANCILLARY	403,209.20	0.00
			TOTAL ACCOMODATIONS	65,320.00	0.00
			TOTAL CHARGES	468,529.20	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,318,883.67	ADJUSTMENTS	1,356,715.53
COVERED CHARGES	19,466,579.67	CONTRACTUAL ALLOW	14,616,338.72
NON-COVERD CHARGES	1,852,304.00	TOTAL MEDICAID LIAB	4,850,240.95
		LESS: COB	16,869.65
		LESS: COPAYMENT	26,775.00
		REIMBURSEMENT	4,806,596.30
		ALL OTHER	4,046,761.49
		FEE SCHEDULE-LAB	416,623.06
		INJECTABLE DRUGS	343,211.75

TOTAL NUMBER OF CLAIMS 14,989



THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	668,106.28	10,142.10	OTHER LAB	159,692.50	108.35
MED/SURG SUPPLY	680,003.68	5,247.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	469.14	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	827,694.50	19,522.66	OTHER THERAPEUTIC SVC	334.00	668.00
CT SCAN	1,804,400.84	204,252.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	63,546.00	11,290.00	FEE SCHEDULE LAB	3,275,359.20	760,045.63
EKG/ECG	178,909.25	6,112.25	MRI SERVICES	766,734.43	39,234.20
IV THERAPY	405,682.10	3,343.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,058,968.32	96,069.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,792.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	196,218.99	137,932.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,629.00	1,322.00	AMBULANCE	0.00	0.00
GI SERVICES	6,733.20	3,812.61	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,518,159.17	10,625.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	362,380.00	1,278.00	DRUG-SPECIFIC/HOME IV	6,261.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,891,252.02	378,917.75
RADIOLOGY THERAPEUTIC	940,842.35	47,698.39	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,649.00	12,294.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,376.00	3,514.47	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,806.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	730,698.78	34,825.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	134,308.65	5,355.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	55.45
OTHER IMAGING SERVICE	780,701.35	34,003.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	165,531.00	3,983.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	147,929.89	1,663.25			
AUDIOLOGY	1,862.00	596.49			
CARDIOLOGY	232,279.53	13,116.00			
AMBULATORY SURGERY	6,248.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,844.65	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	289,451.79	0.00			
			TOTAL ANCILLARY	19,466,579.67	1,852,304.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,466,579.67	1,852,304.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
25	2212205003939	04/22/12 - 04/23/12	07/30/12	0.00	55.45	0.00	0.00	0.00
TOTAL				0.00	55.45	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

THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	640,562.38	ADJUSTMENTS	0.00
COVERED CHARGES	519,104.07	CONTRACTUAL ALLOW	155,419.20
NON-COVERD CHARGES	121,458.31	TOTAL MEDICAID LIAB	363,684.87
		LESS: COB	363,489.47
		LESS: COPAYMENT	195.40
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 162

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,178.60	198.05	OTHER LAB	356.49	0.00
MED/SURG SUPPLY	14,000.00	3,900.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,831.22	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,004.49	7,410.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,867.00	2,971.00	FEE SCHEDULE LAB	39,163.95	9,104.90
EKG/ECG	1,391.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	35,993.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,874.70	9,174.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,951.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,304.35	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,340.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,998.89	180.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,511.50	0.00	DRUG-SPECIFIC/HOME IV	6,261.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	192,560.70	71,835.25
RADIOLOGY THERAPEUTIC	16,282.60	623.63	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	106.00	654.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,012.56	813.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	261.00	2,410.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,017.86	11,930.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,094.00	252.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,886.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	840.56	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,014.65	0.00			
			TOTAL ANCILLARY	519,104.07	121,458.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	519,104.07	121,458.31

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

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THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	548,917.41	ADJUSTMENTS	3,051.63
COVERED CHARGES	525,298.12	CONTRACTUAL ALLOW	492,461.34
NON-COVERD CHARGES	23,619.29	TOTAL MEDICAID LIAB	32,836.78
		LESS: COB	0.00
		LESS: COPAYMENT	873.07
		REIMBURSEMENT	31,963.71
		TOTAL NUMBER OF CLAIMS	587

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,588.00	288.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,138.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,032.35	209.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,489.00	2,964.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	120,600.88	16,571.57
EKG/ECG	3,896.20	0.00	MRI SERVICES	6,589.86	0.00
IV THERAPY	4,682.71	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	993.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,247.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,136.14	510.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	255,759.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,243.98	279.05
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	5,801.33	361.92	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	8,521.21	2,183.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,083.00	252.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,495.50	0.00			
			TOTAL ANCILLARY	525,298.12	23,619.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	525,298.12	23,619.29

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: 09/24/2013  
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THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER 000001196A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,644.77	ADJUSTMENTS	0.00
COVERED CHARGES	18,433.67	CONTRACTUAL ALLOW	7,534.06
NON-COVERD CHARGES	1,211.10	TOTAL MEDICAID LIAB	10,899.61
		LESS: COB	10,884.61
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	19

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	135.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	255.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,759.70	1,211.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	409.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	321.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,791.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	124.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	637.77	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	18,433.67	1,211.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,433.67	1,211.10



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,109,060.19	ADJUSTMENTS	382,220.14
COVERED CHARGES	4,853,440.53	CONTRACTUAL ALLOW	4,010,973.56
NON-COVERD CHARGES	255,619.66	TOTAL MEDICAID LIAB	842,466.97
		LESS: COB	15,702.37
		LESS: COPAYMENT	2,696.61
		REIMBURSEMENT	824,067.99
		TOTAL NUMBER OF CLAIMS	155

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,266.90	0.00	OTHER LAB	10,117.71	0.00
MED/SURG SUPPLY	120,819.75	929.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	118.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,136.17	3,887.42	OTHER THERAPEUTIC SVC	0.00	2,505.00
CT SCAN	122,379.00	3,305.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	522.00	FEE SCHEDULE LAB	98,551.67	64,310.85
EKG/ECG	1,948.10	0.00	MRI SERVICES	4,671.49	2,978.13
IV THERAPY	195,193.14	3,871.63	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	199,342.76	10,535.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	136,262.78	24,829.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,506.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,327.95	256.09	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,907.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,928,881.99	78,871.30
RADIOLOGY THERAPEUTIC	1,457,593.00	52,578.99	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	816.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	390.49	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	801.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27,390.60	668.35	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,877.00	272.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	195.14
OTHER IMAGING SERVICE	36,848.36	2,726.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	142,184.00	252.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	46,529.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,850.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,855.16	0.00			
			TOTAL ANCILLARY	4,853,440.53	255,619.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,853,440.53	255,619.66

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8004	5912145001712	08/17/11 - 08/17/11	05/28/12	0.00	195.14	0.00	0.00	0.00
TOTAL				0.00	195.14	0.00	0.00	0.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VIII

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	185,206.50	ADJUSTMENTS	0.00
COVERED CHARGES	173,482.71	CONTRACTUAL ALLOW	42,698.26
NON-COVERD CHARGES	11,723.79	TOTAL MEDICAID LIAB	130,784.45
		LESS: COB	130,688.45
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145.80	675.65	OTHER LAB	0.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,034.75	376.19
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,229.60	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	145,317.85	10,671.95
RADIOLOGY THERAPEUTIC	12,070.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,356.71	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,932.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	173,482.71	11,723.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	173,482.71	11,723.79

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER 000001207A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	155,908,045.92	ADJUSTMENTS	10,591,959.36
COVERED CHARGES	153,488,226.96	CONTRACTUAL ALLOW	107,435,276.61
NON-COVERD CHARGES	2,419,818.96	TOTAL MEDICAID LIAB	46,052,950.35
		LESS: COB	423,173.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	45,629,776.64

TOTAL NUMBER OF ADMISSIONS 3,687

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	17,388		0	11,585,405.00		552,670.00
ROUTINE NURSERY	988		0	642,625.00		60,480.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	18,376		0	12,228,030.00		613,150.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4,798		0	10,054,874.00		8,445.00
NICU	2,244		0	4,447,025.00		0.00
PED ICU	820		0	1,965,600.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7,862		0	16,467,499.00		8,445.00
TOTAL ACCOMODATIONS	26,238		0	28,695,529.00		621,595.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,111,664.72	353,690.37	OTHER LAB	741,269.00	720.00
MED/SURG SUPPLY	9,599,143.15	246,994.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,714,387.91	111,441.00	EDUCATION & TRAINING	70.00	0.00
RADIOLOGY-DIAGNOSTIC	3,744,975.00	7,151.00	OTHER THERAPEUTIC SVC	0.00	330,282.00
CT SCAN	5,898,739.00	144,233.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	549,523.00	10,779.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	647,283.00	592.00	MRI SERVICES	1,907,446.00	0.00
IV THERAPY	1,596,012.00	70,350.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,495,549.05	44,706.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,439,671.00	3,752.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,417,063.00	204,374.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,230,454.00	819.00	AMBULANCE	0.00	0.00
GI SERVICES	34,383.00	2,949.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,192,622.00	12,250.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,141,558.00	2,148.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	252,771.26	126.00	INJECTABLE DRUGS	832,369.99	42.42
RADIOLOGY THERAPEUTIC	58,903.00	186.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	294,816.00	2,761.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	386,142.00	8,099.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	739,977.00	102,784.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	50.00	54,194.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	106,506.00	49.00	IMPL DEV CHARGE PATIENTS	6,767,845.88	992.00
LITHOTRIPSY	7,340.00	0.00	NO CC/INVALID REV CODE	0.00	852.00
OTHER IMAGING SERVICE	482,026.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,894,668.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	549,875.00	29,536.00			
AUDIOLOGY	298.00	0.00			
CARDIOLOGY	7,489,339.00	11,591.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,040.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,361,918.00	39,781.00			
			TOTAL ANCILLARY	124,792,697.96	1,798,223.96
			TOTAL ACCOMODATIONS	28,695,529.00	621,595.00
			TOTAL CHARGES	153,488,226.96	2,419,818.96

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: 09/24/2013  
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MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3234	2212004006682	10/26/11 - 12/01/11	01/09/12	0.00	852.00	0.00	0.00	0.00
TOTAL				0.00	852.00	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: 09/24/2013  
 Run Time: 17:33:04  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	646,807.92	ADJUSTMENTS	0.00
COVERED CHARGES	641,566.92	CONTRACTUAL ALLOW	482,744.89
NON-COVERD CHARGES	5,241.00	TOTAL MEDICAID LIAB	158,822.03
		LESS: COB	158,822.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32		0	21,920.00		685.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	32		0	21,920.00		685.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	24		0	45,750.00		0.00
NICU	0		0	0.00		0.00
PED ICU	9		0	21,600.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	33		0	67,350.00		0.00
TOTAL ACCOMODATIONS	65		0	89,270.00		685.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	147,179.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	46,746.00	3,041.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	55,295.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,716.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,515.00
CT SCAN	17,560.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,249.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,128.00	0.00	MRI SERVICES	2,861.00	0.00
IV THERAPY	798.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,079.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,367.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,368.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,092.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,026.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	645.00	0.00	INJECTABLE DRUGS	87,279.99	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	327.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	490.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,116.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	533.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,883.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,486.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,072.00	0.00			
			TOTAL ANCILLARY	552,296.92	4,556.00
			TOTAL ACCOMODATIONS	89,270.00	685.00
			TOTAL CHARGES	641,566.92	5,241.00

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: 09/24/2013  
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MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,769,421.67	ADJUSTMENTS	3,491,325.66
COVERED CHARGES	46,611,214.45	CONTRACTUAL ALLOW	35,458,799.04
NON-COVERD CHARGES	3,158,207.22	TOTAL MEDICAID LIAB	11,152,415.41
		LESS: COB	44,272.51
		LESS: COPAYMENT	37,735.62
		REIMBURSEMENT	11,070,407.28
		ALL OTHER	9,103,776.23
		FEE SCHEDULE-LAB	1,139,852.74
		INJECTABLE DRUGS	826,778.31

TOTAL NUMBER OF CLAIMS 28,673

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,098,465.11	3,250.24	OTHER LAB	278,383.00	722.00
MED/SURG SUPPLY	1,876,783.85	7,785.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,955,538.00	64,858.00	OTHER THERAPEUTIC SVC	9,150.00	0.00
CT SCAN	3,196,830.00	101,480.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,502.00	6,348.00	FEE SCHEDULE LAB	7,896,911.45	1,708,053.90
EKG/ECG	337,999.00	10,723.00	MRI SERVICES	88,502.00	18,356.00
IV THERAPY	1,940,312.00	314,732.00	PROFESSIONAL FEES	0.00	334.25
OPERATING ROOM	4,035,724.00	312,075.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	327,267.00	2,774.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	367,507.00	7,335.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	795,729.00	2,375.00	AMBULANCE	0.00	0.00
GI SERVICES	102,766.00	2,949.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,568,940.00	13,045.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,531,732.00	1,550.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,109,937.04	236,915.82
RADIOLOGY THERAPEUTIC	107,631.00	4,796.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,119.00	1,566.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	48,338.00	3,529.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,467.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,228,920.00	29,719.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	214.00	341.00	IMPL DEV CHARGE PATIENTS	313,221.00	110,701.00
LITHOTRIPSY	7,340.00	0.00	NO CC/INVALID REV CODE	0.00	65.00
OTHER IMAGING SERVICE	505,656.00	20,204.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	386,434.00	4,849.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	692,198.00	28,589.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,949,499.00	126,278.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	161,501.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,651,165.00	7,442.00			
			TOTAL ANCILLARY	46,611,214.45	3,158,207.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,611,214.45	3,158,207.22

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3031	2212207009212	05/14/12 - 05/14/12	07/30/12	0.00	65.00	0.00	0.00	0.00
TOTAL				0.00	65.00	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: 09/24/2013  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	317,543.29	ADJUSTMENTS	0.00
COVERED CHARGES	281,934.04	CONTRACTUAL ALLOW	236,645.10
NON-COVERD CHARGES	35,609.25	TOTAL MEDICAID LIAB	45,288.94
		LESS: COB	45,189.95
		LESS: COPAYMENT	98.99
		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

MEDICAL CENTER OF CENTRAL GEORGIA PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/11 THROUGH 09/30/12  
 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	16,095.68	0.00	OTHER LAB	758.00	0.00
MED/SURG SUPPLY	11,246.00	13.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,651.00	929.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,293.00	8,005.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,112.00	FEE SCHEDULE LAB	17,267.00	2,120.00
EKG/ECG	282.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,666.00	3,424.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,660.00	13,054.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	833.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,866.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,197.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,949.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,771.00	665.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,056.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127,919.36	1,795.39
RADIOLOGY THERAPEUTIC	3,965.00	436.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	459.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,751.00	192.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,798.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	333.86
OTHER IMAGING SERVICE	4,392.00	483.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,032.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,444.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,252.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,280.00	98.00			
			TOTAL ANCILLARY	281,934.04	35,609.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	281,934.04	35,609.25

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
528	5012216900003	10/12/11 - 10/12/11	08/13/12	0.00	333.86	0.00	1,643.50	0.00
TOTAL				0.00	333.86	0.00	1,643.50	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: 09/24/2013  
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MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	617,976.64	ADJUSTMENTS	6,533.67
COVERED CHARGES	596,443.69	CONTRACTUAL ALLOW	558,478.45
NON-COVERD CHARGES	21,532.95	TOTAL MEDICAID LIAB	37,965.24
		LESS: COB	317.63
		LESS: COPAYMENT	1,386.06
		REIMBURSEMENT	36,261.55
		TOTAL NUMBER OF CLAIMS	673

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:37:31  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,801.70	3.13	OTHER LAB	1,191.00	0.00
MED/SURG SUPPLY	6,396.00	519.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,734.00	0.00	OTHER THERAPEUTIC SVC	72.00	0.00
CT SCAN	12,059.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	327.00	0.00	FEE SCHEDULE LAB	73,418.00	18,188.00
EKG/ECG	4,794.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,898.00	1,054.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	554.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,359.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,594.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	387,350.00	42.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,956.99	694.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,247.00	66.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	171.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,928.00	966.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,593.00	0.00			
			TOTAL ANCILLARY	596,443.69	21,532.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	596,443.69	21,532.95

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

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,727.31	ADJUSTMENTS	0.00
COVERED CHARGES	9,035.31	CONTRACTUAL ALLOW	8,470.31
NON-COVERD CHARGES	692.00	TOTAL MEDICAID LIAB	565.00
		LESS: COB	562.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	464.31	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	814.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,827.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,864.00	692.00
EKG/ECG	282.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,743.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,035.31	692.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,035.31	692.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,621,678.41	ADJUSTMENTS	561,146.20
COVERED CHARGES	7,682,602.35	CONTRACTUAL ALLOW	6,470,774.89
NON-COVERD CHARGES	939,076.06	TOTAL MEDICAID LIAB	1,211,827.46
		LESS: COB	0.00
		LESS: COPAYMENT	820.88
		REIMBURSEMENT	1,211,006.58

TOTAL NUMBER OF CLAIMS 213

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/11 THROUGH 09/30/12  
 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	467,774.54	3,044.44	OTHER LAB	111,901.00	7,722.00
MED/SURG SUPPLY	673,679.00	3,042.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	276,645.00	62,560.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,964.00	17,802.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	408.00	408.00	FEE SCHEDULE LAB	215,358.20	57,074.70
EKG/ECG	26,508.00	3,243.00	MRI SERVICES	17,476.00	2,861.00
IV THERAPY	106,655.00	44,007.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	678,037.00	220,354.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	155,404.00	17,695.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,717.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,887.00	1,423.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,349.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	719,560.61	50,915.92
RADIOLOGY THERAPEUTIC	14,132.00	1,744.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,556.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,954.00	279.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	53.00	IMPL DEV CHARGE PATIENTS	2,449,338.00	223,447.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,864.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,364.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,870.00	243.00			
AUDIOLOGY	1.00	0.00			
CARDIOLOGY	1,152,170.00	195,249.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,212.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	282,374.00	17,353.00			
			TOTAL ANCILLARY	7,682,602.35	939,076.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,682,602.35	939,076.06

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:38:13  
 Page: 1

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,285,392.71	ADJUSTMENTS	39,429.35
COVERED CHARGES	1,214,521.71	CONTRACTUAL ALLOW	356,885.30
NON-COVERD CHARGES	70,871.00	TOTAL MEDICAID LIAB	857,636.41
		LESS: COB	6,157.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	851,478.72

TOTAL NUMBER OF ADMISSIONS 133

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	432		0	137,920.00		2,485.00
ROUTINE NURSERY	33		0	10,560.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	465		0	148,480.00		2,485.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	69		0	46,575.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	69		0	46,575.00		0.00
TOTAL ACCOMODATIONS	534		0	195,055.00		2,485.00



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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	350,186.80	0.00	OTHER LAB	3,591.00	0.00
MED/SURG SUPPLY	86,536.56	213.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	242,851.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,827.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	66,952.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,905.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,810.00	0.00	MRI SERVICES	3,348.00	0.00
IV THERAPY	2,761.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,282.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,243.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	84,175.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,381.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,405.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,142.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,931.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	275.00	0.00	INJECTABLE DRUGS	343.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	500.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	269.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,469.00	0.00			
BLOOD	2,887.00	0.00			
BLOOD STORAGE & PRO.	28,796.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,966.00	0.00			
AUDIOLOGY	0.00	650.00			
CARDIOLOGY	7,776.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,808.00	571.00			
			TOTAL ANCILLARY	1,019,466.71	68,386.00
			TOTAL ACCOMODATIONS	195,055.00	2,485.00
			TOTAL CHARGES	1,214,521.71	70,871.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,896,696.62	ADJUSTMENTS	95,582.54
COVERED CHARGES	1,605,222.22	CONTRACTUAL ALLOW	1,103,534.69
NON-COVERD CHARGES	291,474.40	TOTAL MEDICAID LIAB	501,687.53
		LESS: COB	495.78
		LESS: COPAYMENT	2,208.00
		REIMBURSEMENT	498,983.75
		ALL OTHER	385,084.67
		FEE SCHEDULE-LAB	91,135.06
		INJECTABLE DRUGS	22,764.02

TOTAL NUMBER OF CLAIMS 2,053

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,626.94	61,650.94	OTHER LAB	11,286.00	594.00
MED/SURG SUPPLY	51,026.50	7,443.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	196.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,210.50	2,984.50	OTHER THERAPEUTIC SVC	0.00	3,727.00
CT SCAN	150,417.00	54,477.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,483.00	7,447.00	FEE SCHEDULE LAB	438,269.50	71,160.00
EKG/ECG	13,822.00	0.00	MRI SERVICES	32,888.00	1,642.00
IV THERAPY	18,740.00	1,556.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,089.00	25,013.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,490.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,498.50	332.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,739.00	648.00	AMBULANCE	0.00	0.00
GI SERVICES	27,837.50	8,610.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	267,455.00	3,733.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	147,711.83	33,156.14
RADIOLOGY THERAPEUTIC	8,883.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,451.00	3,258.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	375.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,417.00	1,415.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,546.50	560.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,890.50	552.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,031.00	0.00			
AUDIOLOGY	0.00	100.00			
CARDIOLOGY	8,640.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,500.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,297.45	1,217.77			
			TOTAL ANCILLARY	1,605,222.22	291,474.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,605,222.22	291,474.40

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WASHINGTON COUNTY REGIONAL MEDICAL  
610 SPARTA ROAD  
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER  
000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,600.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,851.15	CONTRACTUAL ALLOW	3,443.44
NON-COVERD CHARGES	1,748.85	TOTAL MEDICAID LIAB	4,407.71
		LESS: COB	4,396.98
		LESS: COPAYMENT	10.73
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19.50	59.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	193.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,530.50	75.50	OTHER THERAPEUTIC SVC	0.00	150.00
CT SCAN	0.00	675.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,104.50	102.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	378.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,276.00	150.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	160.55	236.05
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	125.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	189.00	175.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,851.15	1,748.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,851.15	1,748.85

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: 09/24/2013  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,693.25	ADJUSTMENTS	552.73
COVERED CHARGES	51,345.50	CONTRACTUAL ALLOW	43,809.63
NON-COVERD CHARGES	6,347.75	TOTAL MEDICAID LIAB	7,535.87
		LESS: COB	15.00
		LESS: COPAYMENT	282.02
		REIMBURSEMENT	7,238.85
		TOTAL NUMBER OF CLAIMS	138

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 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	337.60	1,988.13	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	809.00	13.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,366.50	68.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,971.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,797.50	2,640.50
EKG/ECG	390.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	255.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,156.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	522.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	648.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,583.00	1,025.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	445.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,737.90	612.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	326.00	0.00			
			TOTAL ANCILLARY	51,345.50	6,347.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,345.50	6,347.75



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	217.78	ADJUSTMENTS	0.00
COVERED CHARGES	217.78	CONTRACTUAL ALLOW	100.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	117.78
		LESS: COB	117.78
		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: 09/24/2013  
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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 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57.78	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	160.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	217.78	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	217.78	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	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
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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	09/01/11	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER 000001229A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,592,764.37	ADJUSTMENTS	386,826.44
COVERED CHARGES	15,026,276.91	CONTRACTUAL ALLOW	9,438,209.20
NON-COVERD CHARGES	566,487.46	TOTAL MEDICAID LIAB	5,588,067.71
		LESS: COB	46,958.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,541,109.41

TOTAL NUMBER OF ADMISSIONS 673

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,653	0	1,592,235.00	140,865.00
ROUTINE NURSERY	120	0	52,685.00	2,870.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,773	0	1,644,920.00	143,735.00
SPECIAL CARE SERVICES				
CCU	467	0	520,490.00	0.00
ICU	281	0	364,015.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	748	0	884,505.00	0.00
TOTAL ACCOMODATIONS	3,521	0	2,529,425.00	143,735.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,257,377.96	2,212.00	OTHER LAB	116,439.00	0.00
MED/SURG SUPPLY	1,410,631.74	5,267.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,543,267.00	2,065.00	EDUCATION & TRAINING	979.00	0.00
RADIOLOGY-DIAGNOSTIC	323,955.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	588,956.00	357,826.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	118,662.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	155,875.00	0.00	MRI SERVICES	227,884.00	0.00
IV THERAPY	199,501.00	1,451.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,161,822.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,109.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	782,804.00	7,654.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	774.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	172,078.40	2,528.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	366,685.00	348.00	SPECIAL SERVICES	0.00	1,424.00
RECOVERY ROOM	56,421.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	15,965.00
LABORATORY PATHOLOGIC	23,148.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	92.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,809.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,327.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	108,927.00	7,644.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120.00	2,910.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	382,598.57	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	389.00
OTHER IMAGING SERVICE	84,234.00	0.00			
BLOOD	2,425.00	0.00			
BLOOD STORAGE & PRO.	193,847.00	10,440.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	220,817.00	0.00			
AUDIOLOGY	6,201.00	0.00			
CARDIOLOGY	767,380.04	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,272.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149,525.00	4,537.00			
			TOTAL ANCILLARY	12,496,851.91	422,752.46
			TOTAL ACCOMODATIONS	2,529,425.00	143,735.00
			TOTAL CHARGES	15,026,276.91	566,487.46

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: 09/24/2013  
Run Time: 17:38:57  
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MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1112109000289	03/28/12 - 03/30/12	04/30/12	0.00	389.00	0.00	0.00	0.00
TOTAL				0.00	389.00	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: 09/24/2013  
 Run Time: 17:39:13  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	148,394.21	ADJUSTMENTS	0.00
COVERED CHARGES	143,114.21	CONTRACTUAL ALLOW	41,403.53
NON-COVERD CHARGES	5,280.00	TOTAL MEDICAID LIAB	101,710.68
		LESS: COB	101,710.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	21		0	12,435.00		1,005.00
ROUTINE NURSERY	2		0	860.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	23		0	13,295.00		1,005.00
SPECIAL CARE SERVICES						
CCU	2		0	2,590.00		0.00
ICU	3		0	3,885.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,475.00		0.00
TOTAL ACCOMODATIONS	28		0	19,770.00		1,005.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,745.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,819.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,936.00	0.00	EDUCATION & TRAINING	34.00	0.00
RADIOLOGY-DIAGNOSTIC	1,222.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,100.00	3,927.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	216.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	880.00	0.00	MRI SERVICES	9,155.00	0.00
IV THERAPY	244.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,609.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,146.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,876.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,194.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	88.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,464.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,378.00	348.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	117.00	0.00			
CARDIOLOGY	7,329.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,390.00	0.00			
			TOTAL ANCILLARY	123,344.21	4,275.00
			TOTAL ACCOMODATIONS	19,770.00	1,005.00
			TOTAL CHARGES	143,114.21	5,280.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 17:39:16  
Page: 6

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,034,048.75	ADJUSTMENTS	699,581.29
COVERED CHARGES	14,740,157.89	CONTRACTUAL ALLOW	11,256,339.70
NON-COVERD CHARGES	1,293,890.86	TOTAL MEDICAID LIAB	3,483,818.19
		LESS: COB	3,881.08
		LESS: COPAYMENT	8,200.18
		REIMBURSEMENT	3,471,736.93
		ALL OTHER	2,911,365.26
		FEE SCHEDULE-LAB	375,692.65
		INJECTABLE DRUGS	184,679.02
		TOTAL NUMBER OF CLAIMS	8,912

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	735,953.85	3,119.30	OTHER LAB	398,845.00	0.00
MED/SURG SUPPLY	633,284.84	5,423.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	227.00	EDUCATION & TRAINING	159.00	68.00
RADIOLOGY-DIAGNOSTIC	658,955.00	32,144.00	OTHER THERAPEUTIC SVC	258.00	0.00
CT SCAN	1,959,699.00	54,628.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,272.00	10,112.00	FEE SCHEDULE LAB	1,695,730.00	246,011.00
EKG/ECG	187,778.00	4,928.00	MRI SERVICES	558,800.00	39,253.00
IV THERAPY	512,158.00	152,255.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,516,009.68	152,306.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,241.00	219.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	105,394.00	6,720.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	3,483.00	AMBULANCE	0.00	0.00
GI SERVICES	619,958.54	57,391.16	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,672,486.90	33,363.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	239,436.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,775.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	742,421.99	246,201.25
RADIOLOGY THERAPEUTIC	0.00	1,656.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,317.00	6,831.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,683.00	1,950.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,911.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	97,958.00	6,656.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	127,918.99	27,881.35
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	645,379.00	43,909.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	35,005.00	348.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	443,096.00	36,637.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	691,813.00	80,822.68			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,765.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	348,382.10	34,661.00			
			TOTAL ANCILLARY	14,740,157.89	1,293,890.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,740,157.89	1,293,890.86

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 17:40:31  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	194,104.98	ADJUSTMENTS	0.00
COVERED CHARGES	157,054.56	CONTRACTUAL ALLOW	79,382.06
NON-COVERD CHARGES	37,050.42	TOTAL MEDICAID LIAB	77,672.50
		LESS: COB	77,612.77
		LESS: COPAYMENT	59.73
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 128

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357  
PROVIDER NUMBER  
000001229A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,700.89	441.90	OTHER LAB	594.00	0.00
MED/SURG SUPPLY	8,662.79	472.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,128.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,653.00	5,685.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,501.00	4,587.00
EKG/ECG	3,520.00	176.00	MRI SERVICES	7,242.00	5,237.00
IV THERAPY	9,866.00	616.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,269.28	6,139.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,474.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,105.00	431.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	279.00	AMBULANCE	0.00	0.00
GI SERVICES	7,257.00	2,793.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,706.00	1,909.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,578.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,585.60	3,586.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	184.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	95.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	329.00	180.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,676.00	707.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,666.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,417.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	572.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,552.00	3,531.00			
			TOTAL ANCILLARY	157,054.56	37,050.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	157,054.56	37,050.42

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 17:40:37  
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MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	889,422.96	ADJUSTMENTS	2,577.64
COVERED CHARGES	853,573.61	CONTRACTUAL ALLOW	787,587.75
NON-COVERD CHARGES	35,849.35	TOTAL MEDICAID LIAB	65,985.86
		LESS: COB	3.29
		LESS: COPAYMENT	2,301.09
		REIMBURSEMENT	63,681.48
		TOTAL NUMBER OF CLAIMS	1,180

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,041.05	1,003.75	OTHER LAB	7,436.00	0.00
MED/SURG SUPPLY	20,059.56	974.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	92,488.00	1,966.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	83,886.00	1,354.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	97,796.00	3,122.00
EKG/ECG	10,560.00	0.00	MRI SERVICES	4,675.00	2,414.00
IV THERAPY	59,020.00	8,957.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,747.00	77.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,528.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	386,662.00	984.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,717.00	744.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,820.00	5,635.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,015.00	707.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,651.00	5,383.00			
			TOTAL ANCILLARY	853,573.61	35,849.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	853,573.61	35,849.35

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:40:44  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,638.55	ADJUSTMENTS	0.00
COVERED CHARGES	20,126.15	CONTRACTUAL ALLOW	14,833.01
NON-COVERD CHARGES	1,512.40	TOTAL MEDICAID LIAB	5,293.14
		LESS: COB	5,272.14
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	941.65	0.00	OTHER LAB	582.00	0.00
MED/SURG SUPPLY	512.50	101.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,790.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,185.00	1,329.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,413.00	82.00
EKG/ECG	176.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	872.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,480.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	431.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	650.00	0.00			
			TOTAL ANCILLARY	20,126.15	1,512.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,126.15	1,512.40

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
Run Time: 17:40:46  
Page: 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	691,600.72	ADJUSTMENTS	59,002.84
COVERED CHARGES	623,892.04	CONTRACTUAL ALLOW	521,854.72
NON-COVERD CHARGES	67,708.68	TOTAL MEDICAID LIAB	102,037.32
		LESS: COB	0.00
		LESS: COPAYMENT	186.00
		REIMBURSEMENT	101,851.32

TOTAL NUMBER OF CLAIMS 19

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1900 TEBEAU ST	000001229A	SERVICE DATES	01/01/12	THROUGH	12/31/12
WAYCROSS,GA 31501-6357		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,905.07	0.00	OTHER LAB	106.00	0.00
MED/SURG SUPPLY	46,227.33	85.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	136.00	136.00
RADIOLOGY-DIAGNOSTIC	1,844.00	529.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	216.00	FEE SCHEDULE LAB	14,454.80	3,917.20
EKG/ECG	5,095.00	352.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,575.00	3,910.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,006.50	3,761.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	839.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,100.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,972.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	119,672.48	21,975.00
RADIOLOGY THERAPEUTIC	0.00	92.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	227,191.86	11,837.34
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,584.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,798.00	20,344.84			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,385.00	552.00			
			TOTAL ANCILLARY	623,892.04	67,708.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	623,892.04	67,708.68

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 17:40:49  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:40:57  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,223,268.07	ADJUSTMENTS	72,360.83
COVERED CHARGES	1,169,834.72	CONTRACTUAL ALLOW	459,353.57
NON-COVERD CHARGES	53,433.35	TOTAL MEDICAID LIAB	710,481.15
		LESS: COB	5,811.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	704,669.54

TOTAL NUMBER OF ADMISSIONS 194

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	338		0	144,549.75		12,254.90
ROUTINE NURSERY	131		0	32,849.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	469		0	177,398.75		12,254.90
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	9		0	9,724.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	9		0	9,724.00		0.00
TOTAL ACCOMODATIONS	478		0	187,122.75		12,254.90

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,060.50	0.00	OTHER LAB	25,511.60	864.80
MED/SURG SUPPLY	174,425.56	424.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	174,344.75	839.30	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,118.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,699.01	1,594.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,390.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,187.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	2,175.00
OPERATING ROOM	47,000.35	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	57,082.20	1,120.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,273.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,090.65	32,502.60	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	106,972.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,218.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,727.45	392.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,020.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,335.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,226.60	1,265.30			
ONCOLOGY	187.75	0.00			
NUCLEAR MEDICINE	1,586.55	0.00			
AUDIOLOGY	8,163.20	0.00			
CARDIOLOGY	7,971.50	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	1,119.50	0.00			
			TOTAL ANCILLARY	982,711.97	41,178.45
			TOTAL ACCOMODATIONS	187,122.75	12,254.90
			TOTAL CHARGES	1,169,834.72	53,433.35

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:41:01  
Page: 3

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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 17:41:02  
Page: 4

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,906,995.53	ADJUSTMENTS	8,923.90
COVERED CHARGES	1,672,949.45	CONTRACTUAL ALLOW	1,338,303.96
NON-COVERD CHARGES	234,046.08	TOTAL MEDICAID LIAB	334,645.49
		LESS: COB	3,158.54
		LESS: COPAYMENT	1,308.00
		REIMBURSEMENT	330,178.95
		ALL OTHER	282,532.29
		FEE SCHEDULE-LAB	47,404.65
		INJECTABLE DRUGS	242.01
		TOTAL NUMBER OF CLAIMS	1,538



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,900.35	13,527.75	OTHER LAB	19,240.60	1,434.30
MED/SURG SUPPLY	56,587.03	2,859.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,111.10	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	107,146.95	3,581.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	109,725.51	56,601.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	790.00	695.00	FEE SCHEDULE LAB	419,615.46	100,730.83
EKG/ECG	29,095.80	658.20	MRI SERVICES	49,594.95	0.00
IV THERAPY	49,957.50	4,306.35	PROFESSIONAL FEES	0.00	376.85
OPERATING ROOM	50,591.10	10,340.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	193.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,051.90	358.35	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,789.70	13,255.85	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	523,930.75	3,491.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,077.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,825.75	8,331.10
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	570.00	950.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,755.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	581.15
OTHER IMAGING SERVICE	81,742.70	7,052.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,152.90	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,007.40	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,658.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,704.35	618.00			
			TOTAL ANCILLARY	1,672,949.45	233,617.78
			TOTAL ACCOMODATIONS	0.00	428.30
			TOTAL CHARGES	1,672,949.45	234,046.08

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 17:41:02  
Page: 6

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
626	2211278000946	09/20/11 - 09/20/11	10/10/11	0.00	371.70	0.00	0.00	0.00
8759	2211355003158	10/11/11 - 10/11/11	12/26/11	0.00	209.45	0.00	0.00	0.00
TOTAL				0.00	581.15	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: 09/24/2013  
Run Time: 17:41:26  
Page: 7

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,524.25	ADJUSTMENTS	0.00
COVERED CHARGES	1,253.35	CONTRACTUAL ALLOW	400.67
NON-COVERD CHARGES	270.90	TOTAL MEDICAID LIAB	852.68
		LESS: COB	849.68
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	1,253.35	270.90
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,253.35	270.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,253.35	270.90

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: 09/24/2013  
Run Time: 17:41:27  
Page: 9

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	180,154.70	ADJUSTMENTS	0.00
COVERED CHARGES	176,268.50	CONTRACTUAL ALLOW	160,852.72
NON-COVERD CHARGES	3,886.20	TOTAL MEDICAID LIAB	15,415.78
		LESS: COB	424.58
		LESS: COPAYMENT	549.00
		REIMBURSEMENT	14,442.20
		TOTAL NUMBER OF CLAIMS	273

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,527.95	614.35	OTHER LAB	4,893.50	0.00
MED/SURG SUPPLY	3,133.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	112.85	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,988.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,564.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,052.05	3,057.20
EKG/ECG	877.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	529.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,614.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	110,682.40	101.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,228.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	175.50	0.00			
			TOTAL ANCILLARY	176,268.50	3,886.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	176,268.50	3,886.20

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: 09/24/2013  
Run Time: 17:41:30  
Page: 11

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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 17:41:31  
Page: 12

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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 17:41:31  
Page: 13

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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:41:38  
 Page: 1

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,084,057.62	ADJUSTMENTS	65,265.35
COVERED CHARGES	2,059,369.62	CONTRACTUAL ALLOW	1,146,991.73
NON-COVERD CHARGES	24,688.00	TOTAL MEDICAID LIAB	912,377.89
		LESS: COB	3,863.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	908,514.59

TOTAL NUMBER OF ADMISSIONS 190

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	510		2	275,720.00		16,005.00
ROUTINE NURSERY	70		0	31,840.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	580		2	307,560.00		16,005.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	78		0	85,560.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	78		0	85,560.00		0.00
TOTAL ACCOMODATIONS	658		2	393,120.00		16,005.00

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	387,007.82	0.00	OTHER LAB	8,146.00	0.00
MED/SURG SUPPLY	329,982.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	251,029.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,951.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,715.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,939.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,300.00	0.00	MRI SERVICES	29,079.00	0.00
IV THERAPY	124.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	195,527.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	143,688.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,049.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,692.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,039.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,938.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,426.00	0.00	INJECTABLE DRUGS	256.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	928.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,132.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	660.80	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,032.00
OTHER IMAGING SERVICE	8,216.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,364.00	818.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,428.00	0.00			
AUDIOLOGY	2,764.00	0.00			
CARDIOLOGY	13,611.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,257.00	6,833.00			
			TOTAL ANCILLARY	1,666,249.62	8,683.00
			TOTAL ACCOMODATIONS	393,120.00	16,005.00
			TOTAL CHARGES	2,059,369.62	24,688.00

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: 09/24/2013  
Run Time: 17:41:38  
Page: 3

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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3630	2212034007137	01/18/12 - 01/25/12	02/06/12	0.00	1,032.00	0.00	0.00	0.00
TOTAL				0.00	1,032.00	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: 09/24/2013  
 Run Time: 17:41:50  
 Page: 4

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,537.50	ADJUSTMENTS	0.00
COVERED CHARGES	6,497.50	CONTRACTUAL ALLOW	1,807.89
NON-COVERD CHARGES	40.00	TOTAL MEDICAID LIAB	4,689.61
		LESS: COB	4,689.61
		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	1,110.00		40.00
ROUTINE NURSERY	0		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	1,110.00		40.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,110.00		40.00

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	509.50	0.00	OTHER LAB	138.00	0.00
MED/SURG SUPPLY	171.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	199.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	4,370.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	5,387.50	0.00
			TOTAL ACCOMODATIONS	1,110.00	40.00
			TOTAL CHARGES	6,497.50	40.00

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: 09/24/2013  
Run Time: 17:41:51  
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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,114,385.04	ADJUSTMENTS	187,003.88
COVERED CHARGES	2,765,951.92	CONTRACTUAL ALLOW	2,013,518.61
NON-COVERD CHARGES	348,433.12	TOTAL MEDICAID LIAB	752,433.31
		LESS: COB	9,888.89
		LESS: COPAYMENT	5,629.30
		REIMBURSEMENT	736,915.12
		ALL OTHER	606,113.15
		FEE SCHEDULE-LAB	129,973.36
		INJECTABLE DRUGS	828.61
		TOTAL NUMBER OF CLAIMS	3,750

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 17:41:51  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,928.48	620.12	OTHER LAB	14,421.00	0.00
MED/SURG SUPPLY	167,275.07	11,796.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,296.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199,914.00	5,113.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	276,562.00	56,669.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	45,497.00	16,120.00	FEE SCHEDULE LAB	880,271.30	180,887.30
EKG/ECG	44,700.00	175.00	MRI SERVICES	112,475.00	3,722.00
IV THERAPY	2,380.00	0.00	PROFESSIONAL FEES	0.00	126.00
OPERATING ROOM	233,691.00	45,071.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,064.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,725.00	1,094.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,993.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	326,590.50	1,998.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,924.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,966.42	8,058.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	736.00	396.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	325.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,412.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,010.00
OTHER IMAGING SERVICE	69,783.00	4,652.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,582.00	4,328.00			
ONCOLOGY	18.00	0.00			
NUCLEAR MEDICINE	16,352.00	1,847.00			
AUDIOLOGY	0.00	91.00			
CARDIOLOGY	23,550.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,967.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,174.00	2,038.00			
			TOTAL ANCILLARY	2,765,951.92	348,433.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,765,951.92	348,433.12



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: 09/24/2013  
 Run Time: 17:41:51  
 Page: 8

MEMORIAL HOSPITAL AND MANOR  
 1500 E SHOTWELL ST  
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
 000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3000	2211140015464	04/26/11 - 04/26/11	05/23/11	0.00	32.00	0.00	0.00	0.00
8704	2211189012920	07/02/11 - 07/02/11	07/11/11	0.00	300.00	0.00	0.00	0.00
3008	2211229013103	07/24/11 - 07/24/11	08/22/11	0.00	36.00	0.00	0.00	0.00
3200	2211249002156	08/30/11 - 08/30/11	09/12/11	0.00	217.00	0.00	0.00	0.00
6300	2211262007202	09/12/11 - 09/12/11	09/26/11	0.00	171.00	0.00	0.00	0.00
20	5911280000465	09/27/11 - 09/27/11	10/10/11	0.00	95.00	0.00	0.00	0.00
30	2211341003024	08/15/11 - 08/15/11	12/12/11	0.00	132.00	0.00	0.01	0.00
7630	2211361003144	12/04/11 - 12/04/11	01/02/12	0.00	350.00	0.00	0.00	0.00
3000	2212005011731	12/30/11 - 12/30/11	01/09/12	0.00	79.00	0.00	0.00	0.00
30	2212010011095	11/07/11 - 11/07/11	01/16/12	0.00	158.00	0.00	0.00	0.00
30	2212026011730	01/20/12 - 01/20/12	01/30/12	0.00	227.00	0.00	0.00	0.00
30	2212037008264	01/31/12 - 01/31/12	02/13/12	0.00	171.00	0.00	0.00	0.00
3000	2212058006042	02/17/12 - 02/17/12	03/05/12	0.00	42.00	0.00	0.00	0.00
TOTAL				0.00	2,010.00	0.00	0.01	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 17:43:14  
Page: 9

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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,099.40	ADJUSTMENTS	0.00
COVERED CHARGES	13,480.90	CONTRACTUAL ALLOW	5,673.89
NON-COVERD CHARGES	1,618.50	TOTAL MEDICAID LIAB	7,807.01
		LESS: COB	7,789.01
		LESS: COPAYMENT	18.00
		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

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158.45	65.50	OTHER LAB	435.00	0.00
MED/SURG SUPPLY	574.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	124.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	693.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,427.00	1,240.00
EKG/ECG	175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,315.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	86.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	901.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	244.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22.50	189.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,159.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,427.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	863.00	0.00			
			TOTAL ANCILLARY	13,480.90	1,618.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,480.90	1,618.50

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: 09/24/2013  
Run Time: 17:43:15  
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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	86,084.30	ADJUSTMENTS	503.90
COVERED CHARGES	84,228.30	CONTRACTUAL ALLOW	70,703.01
NON-COVERD CHARGES	1,856.00	TOTAL MEDICAID LIAB	13,525.29
		LESS: COB	36.82
		LESS: COPAYMENT	477.01
		REIMBURSEMENT	13,011.46
		TOTAL NUMBER OF CLAIMS	260

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,110.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,395.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	76.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,404.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	972.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,672.00	1,365.00
EKG/ECG	848.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	154.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,723.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	631.25	110.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,134.00	305.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	185.00	0.00			
			TOTAL ANCILLARY	84,228.30	1,856.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	84,228.30	1,856.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	160.00	ADJUSTMENTS	0.00
COVERED CHARGES	160.00	CONTRACTUAL ALLOW	17.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	143.00
		LESS: COB	143.00
		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: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 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	160.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	160.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	160.00	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: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,202.00	ADJUSTMENTS	4,976.31
COVERED CHARGES	101,784.04	CONTRACTUAL ALLOW	76,902.49
NON-COVERD CHARGES	7,417.96	TOTAL MEDICAID LIAB	24,881.55
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	24,878.55

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: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,663.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	46,991.00	594.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	163.00	530.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	704.00	FEE SCHEDULE LAB	377.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,449.84	5,551.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,410.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	358.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,098.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	273.80	38.80
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	101,784.04	7,417.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	101,784.04	7,417.96

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: 09/24/2013  
Run Time: 17:43:22  
Page: 17

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	04/01/11	THROUGH	03/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:43:29  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER 000001273A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,873,030.31	ADJUSTMENTS	7,601,094.53
COVERED CHARGES	111,287,387.44	CONTRACTUAL ALLOW	77,189,619.19
NON-COVERD CHARGES	4,585,642.87	TOTAL MEDICAID LIAB	34,097,768.25
		LESS: COB	173,119.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	33,924,648.98

TOTAL NUMBER OF ADMISSIONS 3,215

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,139		143	9,462,020.00		2,766,646.00
ROUTINE NURSERY	2,077		9	4,260,332.00		4,517.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		19.00
TOTAL ROUTINE	14,216		152	13,722,352.00		2,771,182.00
SPECIAL CARE SERVICES						
CCU	234		0	653,766.00		0.00
ICU	3,356		38	6,167,776.00		92,082.00
NICU	1,166		0	3,541,995.00		0.00
PED ICU	509		0	1,864,639.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	442		0	1,233,706.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,707		38	13,461,882.00		92,082.00
TOTAL ACCOMODATIONS	19,923		190	27,184,234.00		2,863,264.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,775,825.31	18,275.45	OTHER LAB	598,043.00	0.00
MED/SURG SUPPLY	7,702,041.66	181,238.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,458,050.12	93,001.33	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,683,754.00	1,997.00	OTHER THERAPEUTIC SVC	5,764.00	111,273.00
CT SCAN	4,979,314.00	9,798.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,139,682.00	219.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	341,384.00	0.00	MRI SERVICES	1,461,577.00	0.00
IV THERAPY	1,293,601.00	31,114.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,571,848.93	52,306.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	857,288.00	23,500.00	REHAB THERAPY	17,370.00	156.00
RESPIRATORY SERVICES	4,676,990.83	21,522.93	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,654,178.00	1,620.00	AMBULANCE	0.00	0.00
GI SERVICES	219,772.00	1,482.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,049,293.20	372.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,547,617.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	113,420.60
LABORATORY PATHOLOGIC	295,521.68	488.00	INJECTABLE DRUGS	4,841,152.99	639.00
RADIOLOGY THERAPEUTIC	316,460.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	841,409.00	79.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	357,825.00	266.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	398,311.00	13,745.00	PATIENT CONVENIENCE	0.00	3.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,673.00	6,507.00	TRAUMA RESPONSE	0.00	171,400.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,861,348.55	4,396.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	742,359.00	36,261.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	57,915.00	749,370.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	204,181.00	74,360.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	924,946.00	2,915.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	182,310.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,347.17	653.22			
			TOTAL ANCILLARY	84,103,153.44	1,722,378.87
			TOTAL ACCOMODATIONS	27,184,234.00	2,863,264.00
			TOTAL CHARGES	111,287,387.44	4,585,642.87

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,046,382.83	ADJUSTMENTS	0.00
COVERED CHARGES	1,016,190.83	CONTRACTUAL ALLOW	640,600.56
NON-COVERD CHARGES	30,192.00	TOTAL MEDICAID LIAB	375,590.27
		LESS: COB	375,590.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	72		0	55,860.00		17,556.00
ROUTINE NURSERY	37		0	99,197.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	109		0	155,057.00		17,556.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	30		0	67,375.00		0.00
NICU	13		0	100,155.00		0.00
PED ICU	7		0	25,543.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	2		0	5,582.00		0.00
BURN UNIT	0		0	0.00		0.00
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	198,655.00		0.00
TOTAL ACCOMODATIONS	161		0	353,712.00		17,556.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,881.30	0.00	OTHER LAB	946.00	0.00
MED/SURG SUPPLY	56,906.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	63,834.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,587.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,016.00
CT SCAN	17,309.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,370.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,432.00	0.00	MRI SERVICES	7,146.00	0.00
IV THERAPY	6,060.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	103,316.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,961.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,302.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,943.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,995.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,205.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,751.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,084.00	0.00	INJECTABLE DRUGS	19,330.63	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	975.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	82,148.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,872.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,576.00	11,620.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,717.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,720.92	0.00			
			TOTAL ANCILLARY	662,478.83	12,636.00
			TOTAL ACCOMODATIONS	353,712.00	17,556.00
			TOTAL CHARGES	1,016,190.83	30,192.00

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: 09/24/2013  
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MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,776,542.52	ADJUSTMENTS	968,694.07
COVERED CHARGES	30,807,409.16	CONTRACTUAL ALLOW	24,078,438.36
NON-COVERD CHARGES	3,969,133.36	TOTAL MEDICAID LIAB	6,728,970.80
		LESS: COB	53,043.13
		LESS: COPAYMENT	15,061.68
		REIMBURSEMENT	6,660,865.99
		ALL OTHER	5,810,249.38
		FEE SCHEDULE-LAB	416,037.92
		INJECTABLE DRUGS	434,578.69
		TOTAL NUMBER OF CLAIMS	14,985

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	857,231.63	3,494.55	OTHER LAB	674,089.00	1,368.00
MED/SURG SUPPLY	1,693,671.06	104,148.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	141.00
RADIOLOGY-DIAGNOSTIC	1,433,702.00	31,925.00	OTHER THERAPEUTIC SVC	4,024.00	27,094.00
CT SCAN	3,551,206.00	372,282.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	182,631.00	89,902.00	FEE SCHEDULE LAB	2,904,286.78	760,206.66
EKG/ECG	218,949.00	10,740.00	MRI SERVICES	1,739,686.00	255,558.00
IV THERAPY	1,044,831.00	106,156.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,291,045.29	873,797.61	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	208,180.00	0.00	REHAB THERAPY	0.00	1,057.00
RESPIRATORY SERVICES	147,985.00	13,926.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,823,213.00	3,345.00	AMBULANCE	0.00	0.00
GI SERVICES	302,681.50	47,679.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,251,357.66	26,950.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,188,910.00	2,257.00	DRUG-SPECIFIC/HOME IV	0.00	4,628.25
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,461,164.30	513,905.14
RADIOLOGY THERAPEUTIC	1,000,455.00	106,988.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	48,750.00	51,206.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	32,481.00	16,245.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	681.00	9,183.00	PATIENT CONVENIENCE	0.00	10.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	366,281.00	11,504.00	TRAUMA RESPONSE	0.00	4,285.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	323,998.11	2,380.55
LITHOTRIPSY	42,765.00	0.00	NO CC/INVALID REV CODE	0.00	36.00
OTHER IMAGING SERVICE	902,651.00	97,272.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,742.00	103,868.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	357,704.00	226,317.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	242,144.04	81,540.00			
AMBULATORY SURGERY	0.00	5,587.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	44,285.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	464,627.79	2,150.24			
			TOTAL ANCILLARY	30,807,409.16	3,969,133.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,807,409.16	3,969,133.36



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8721	2212130000509	03/22/12 - 03/22/12	05/14/12	0.00	36.00	0.00	0.00	0.00
TOTAL				0.00	36.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,575,968.25	ADJUSTMENTS	0.00
COVERED CHARGES	710,199.04	CONTRACTUAL ALLOW	278,260.60
NON-COVERD CHARGES	865,769.21	TOTAL MEDICAID LIAB	431,938.44
		LESS: COB	431,658.64
		LESS: COPAYMENT	279.80
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 357

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,539.85	1,397.65	OTHER LAB	27,390.00	0.00
MED/SURG SUPPLY	47,958.96	4,254.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	99.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,986.00	1,399.00	OTHER THERAPEUTIC SVC	0.00	716.00
CT SCAN	35,061.00	45,332.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,851.00	10,064.00	FEE SCHEDULE LAB	68,954.62	32,212.33
EKG/ECG	1,611.00	537.00	MRI SERVICES	75,542.00	36,350.00
IV THERAPY	21,090.00	2,026.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,033.00	79,491.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,056.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,299.00	18,000.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,204.00	4,571.00	AMBULANCE	0.00	0.00
GI SERVICES	5,773.00	7,262.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,985.00	3,468.00	SPECIAL SERVICES	0.00	93.30
RECOVERY ROOM	47,141.00	3,976.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,646.00	356,610.25
RADIOLOGY THERAPEUTIC	21,625.00	9,280.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,877.00	6,562.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	258.00	4,960.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,890.00	695.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,204.18	170,846.26
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	133.70
OTHER IMAGING SERVICE	21,046.00	4,084.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,949.00	37,752.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,133.00	6,109.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,909.00	17,486.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	580.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,606.43	1.00			
			TOTAL ANCILLARY	710,199.04	865,769.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	710,199.04	865,769.21

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
36	2212177005718	01/01/12 - 01/31/12	07/02/12	0.00	44.00	0.00	3,337.16	0.00
363	2212177005718	01/01/12 - 01/31/12	07/02/12	0.00	89.70	0.00	3,337.16	0.00
TOTAL				0.00	133.70	0.00	6,674.32	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: 09/24/2013  
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MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	642,335.57	ADJUSTMENTS	1,918.90
COVERED CHARGES	601,356.97	CONTRACTUAL ALLOW	554,647.07
NON-COVERD CHARGES	40,978.60	TOTAL MEDICAID LIAB	46,709.90
		LESS: COB	0.00
		LESS: COPAYMENT	987.01
		REIMBURSEMENT	45,722.89
		TOTAL NUMBER OF CLAIMS	835

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,103.85	8.40	OTHER LAB	6,359.00	0.00
MED/SURG SUPPLY	7,362.73	208.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,201.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,993.00	14,211.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	608.00	FEE SCHEDULE LAB	62,802.48	17,476.00
EKG/ECG	4,475.00	0.00	MRI SERVICES	5,860.00	0.00
IV THERAPY	18,033.00	1,670.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	76.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	960.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,719.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	377,327.00	248.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,011.65	5,291.10
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	362.00	55.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,979.00	1,127.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	808.26	0.00			
			TOTAL ANCILLARY	601,356.97	40,978.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	601,356.97	40,978.60

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,040.15	ADJUSTMENTS	0.00
COVERED CHARGES	58,534.60	CONTRACTUAL ALLOW	52,808.24
NON-COVERD CHARGES	9,505.55	TOTAL MEDICAID LIAB	5,726.36
		LESS: COB	5,654.34
		LESS: COPAYMENT	72.02
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,462.45	0.00	OTHER LAB	1,223.00	0.00
MED/SURG SUPPLY	407.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	874.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	762.00	4,104.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,547.20	1,678.30
EKG/ECG	179.00	0.00	MRI SERVICES	8,946.00	2,617.00
IV THERAPY	5,698.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	413.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,066.00	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	4,085.75	312.25
RADIOLOGY THERAPEUTIC	17,815.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	372.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	100.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,640.00	694.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	816.00	0.00			
			TOTAL ANCILLARY	58,534.60	9,505.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,534.60	9,505.55



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VII

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,742,807.72	ADJUSTMENTS	282,900.96
COVERED CHARGES	8,896,035.85	CONTRACTUAL ALLOW	7,612,007.85
NON-COVERD CHARGES	846,771.87	TOTAL MEDICAID LIAB	1,284,028.00
		LESS: COB	41,438.45
		LESS: COPAYMENT	2,187.88
		REIMBURSEMENT	1,240,401.67
		TOTAL NUMBER OF CLAIMS	222

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,138.41	16.55	OTHER LAB	3,729.00	3,281.00
MED/SURG SUPPLY	828,316.56	1,096.74	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,316.00	58,902.00	OTHER THERAPEUTIC SVC	0.00	15,631.00
CT SCAN	84,601.00	3,576.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	472.00	5,255.00	FEE SCHEDULE LAB	97,064.03	17,430.00
EKG/ECG	5,191.00	537.00	MRI SERVICES	31,664.00	0.00
IV THERAPY	36,844.20	2,474.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,081,155.69	475,982.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	1,208.00
RESPIRATORY SERVICES	1,772.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	376,008.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,296.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	160,599.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	419.65
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,422,702.10	91,181.90
RADIOLOGY THERAPEUTIC	775,441.00	61,149.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,342.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,552.00	1,944.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,038,310.23	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,381.00	7,524.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	12,588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,921.00	6,137.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	475,472.00	79,096.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,089.63	1.00			
			TOTAL ANCILLARY	8,896,035.85	846,771.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,896,035.85	846,771.87

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	239,299.91	ADJUSTMENTS	0.00
COVERED CHARGES	215,993.76	CONTRACTUAL ALLOW	145,384.76
NON-COVERD CHARGES	23,306.15	TOTAL MEDICAID LIAB	70,609.00
		LESS: COB	70,582.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,611.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31,909.86	17,750.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	3,121.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,002.00	305.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,744.00	1,185.00	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	13,409.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,079.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,266.75	945.15
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	90,972.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	215,993.76	23,306.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	215,993.76	23,306.15

\*\* END 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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	164,094.27	ADJUSTMENTS	0.00
COVERED CHARGES	161,332.27	CONTRACTUAL ALLOW	54,826.26
NON-COVERD CHARGES	2,762.00	TOTAL MEDICAID LIAB	106,506.01
		LESS: COB	1,835.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	104,670.99

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	55		0	28,600.00		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	28,600.00		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	28,600.00		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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,986.50	0.00	OTHER LAB	1,128.00	0.00
MED/SURG SUPPLY	9,546.88	309.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,224.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,778.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,611.00
CT SCAN	10,285.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	468.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,810.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	795.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,574.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,691.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,294.89	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	547.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,496.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	782.00	842.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,910.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,416.00	0.00			
			TOTAL ANCILLARY	132,732.27	2,762.00
			TOTAL ACCOMODATIONS	28,600.00	0.00
			TOTAL CHARGES	161,332.27	2,762.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,109,331.60	ADJUSTMENTS	25,804.07
COVERED CHARGES	912,844.45	CONTRACTUAL ALLOW	603,998.76
NON-COVERD CHARGES	196,487.15	TOTAL MEDICAID LIAB	308,845.69
		LESS: COB	607.03
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	307,503.66
		ALL OTHER	282,522.19
		FEE SCHEDULE-LAB	18,130.00
		INJECTABLE DRUGS	6,851.47

TOTAL NUMBER OF CLAIMS 899



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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,345.81	12,617.40	OTHER LAB	7,791.00	0.00
MED/SURG SUPPLY	34,558.12	1,255.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	8,957.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,714.10	1,536.00	OTHER THERAPEUTIC SVC	0.00	28,004.00
CT SCAN	88,570.00	67,248.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	132.00	FEE SCHEDULE LAB	150,289.80	32,133.20
EKG/ECG	36,093.40	1,778.00	MRI SERVICES	24,742.00	0.00
IV THERAPY	19,674.90	1,154.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,697.00	2,195.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,669.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,180.00	10,890.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	282,399.00	3,745.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,212.12	6,486.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	469.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	30.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,008.00
OTHER IMAGING SERVICE	21,905.00	1,455.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,173.00	842.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,719.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,111.20	0.00			
			TOTAL ANCILLARY	912,844.45	183,937.15
			TOTAL ACCOMODATIONS	0.00	12,550.00
			TOTAL CHARGES	912,844.45	196,487.15

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
325	2212030011703	01/15/12 - 01/16/12	02/06/12	0.00	2,500.00	0.00	0.00	0.00
3020	2212088015484	03/05/12 - 03/05/12	04/02/12	0.00	226.00	0.00	0.00	0.00
3020	2212088015484	03/05/12 - 03/05/12	04/02/12	0.00	186.00	0.00	0.00	0.00
4703	2212290003522	10/11/12 - 10/11/12	10/22/12	0.00	96.00	0.00	0.00	0.00
TOTAL				0.00	3,008.00	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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,668.50	ADJUSTMENTS	0.00
COVERED CHARGES	5,029.50	CONTRACTUAL ALLOW	632.85
NON-COVERD CHARGES	1,639.00	TOTAL MEDICAID LIAB	4,396.65
		LESS: COB	4,396.65
		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

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	259.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	46.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	432.00
CT SCAN	0.00	1,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,704.00	30.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,818.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,029.50	1,639.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,029.50	1,639.00

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	113,971.75	ADJUSTMENTS	235.00
COVERED CHARGES	106,439.35	CONTRACTUAL ALLOW	95,889.35
NON-COVERD CHARGES	7,532.40	TOTAL MEDICAID LIAB	10,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	435.00
		REIMBURSEMENT	10,115.00
		TOTAL NUMBER OF CLAIMS	211

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,236.05	58.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	737.00	156.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	69.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,721.00	0.00	OTHER THERAPEUTIC SVC	0.00	4,354.00
CT SCAN	4,708.00	1,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,171.00	1,444.00
EKG/ECG	1,524.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	808.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	71,254.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,610.30	273.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	670.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	106,439.35	7,532.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,439.35	7,532.40

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

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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,110.00	ADJUSTMENTS	0.00
COVERED CHARGES	933.00	CONTRACTUAL ALLOW	-34.06
NON-COVERD CHARGES	1,177.00	TOTAL MEDICAID LIAB	967.06
		LESS: COB	967.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER HEALTHCARE, LLC  
 5995 SPRING ST  
 WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER  
 000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 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	1,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	66.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	867.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	933.00	1,177.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	933.00	1,177.00



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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,707.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,707.00	CONTRACTUAL ALLOW	10,163.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,543.41
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,540.41
		TOTAL NUMBER OF CLAIMS	1

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,479.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	216.00	0.00			
			TOTAL ANCILLARY	14,707.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,707.00	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: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL  
 209 N CUTHBERT ST  
 COLQUITT,GA 39837-3518

PROVIDER NUMBER 000001317A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	626,139.79	ADJUSTMENTS	31,240.29
COVERED CHARGES	623,372.79	CONTRACTUAL ALLOW	288,012.43
NON-COVERD CHARGES	2,767.00	TOTAL MEDICAID LIAB	335,360.36
		LESS: COB	2,217.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	333,143.05

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	193		0	73,920.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	193		0	73,920.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	193		0	73,920.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL  
 209 N CUTHBERT ST  
 COLQUITT,GA 39837-3518

PROVIDER NUMBER 000001317A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	193,236.64	0.00	OTHER LAB	3,925.00	0.00
MED/SURG SUPPLY	89,150.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	82,643.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,428.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	56,558.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,067.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,443.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,672.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,986.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	363.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,550.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,816.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	595.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,604.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,700.00	2,320.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,994.00	447.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,653.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,128.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,941.00	0.00			
			TOTAL ANCILLARY	549,452.79	2,767.00
			TOTAL ACCOMODATIONS	73,920.00	0.00
			TOTAL CHARGES	623,372.79	2,767.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:49:52  
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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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,179,807.12	ADJUSTMENTS	53,496.60
COVERED CHARGES	1,070,413.97	CONTRACTUAL ALLOW	716,162.91
NON-COVERD CHARGES	109,393.15	TOTAL MEDICAID LIAB	354,251.06
		LESS: COB	53.89
		LESS: COPAYMENT	1,917.00
		REIMBURSEMENT	352,280.17
		ALL OTHER	296,303.60
		FEE SCHEDULE-LAB	55,976.57
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,872

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,769.52	669.15	OTHER LAB	20,858.00	0.00
MED/SURG SUPPLY	69,174.30	114.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	298.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,030.30	3,013.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,984.00	4,457.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,940.00	209.00	FEE SCHEDULE LAB	335,371.00	70,073.00
EKG/ECG	12,050.00	1,962.00	MRI SERVICES	7,865.00	1,936.00
IV THERAPY	7,240.00	420.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	100,706.65	14,386.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,225.00	1,131.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,001.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	141,928.00	307.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,810.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,884.00	314.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	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	28,512.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,520.00	6,984.00			
ONCOLOGY	320.30	0.00			
NUCLEAR MEDICINE	2,262.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,007.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,955.90	3,050.00			
			TOTAL ANCILLARY	1,070,413.97	109,393.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,070,413.97	109,393.15



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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8100	2211265001060	09/15/11 - 09/15/11	09/26/11	0.00	35.00	0.00	0.00	0.00
30	2212051008764	02/15/12 - 02/15/12	02/27/12	0.00	35.00	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: 09/24/2013  
Run Time: 17:50:25  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,249.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,179.00	CONTRACTUAL ALLOW	2,441.14
NON-COVERD CHARGES	70.00	TOTAL MEDICAID LIAB	5,737.86
		LESS: COB	5,729.03
		LESS: COPAYMENT	8.83
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,313.00	70.00
EKG/ECG	0.00	0.00	MRI SERVICES	3,872.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,492.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	866.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	308.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	262.00	0.00			
			TOTAL ANCILLARY	8,179.00	70.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,179.00	70.00

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: 09/24/2013  
Run Time: 17:50:26  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,150.15	ADJUSTMENTS	1,061.00
COVERED CHARGES	55,028.15	CONTRACTUAL ALLOW	48,928.15
NON-COVERD CHARGES	122.00	TOTAL MEDICAID LIAB	6,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	5,863.00
		TOTAL NUMBER OF CLAIMS	122

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,044.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	845.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,795.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,887.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,718.00	77.00
EKG/ECG	218.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,317.00	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	45.00
OTHER IMAGING SERVICE	1,204.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	55,028.15	122.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	55,028.15	122.00

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: 09/24/2013  
Run Time: 17:50:26  
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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	5913196000810	11/15/11 - 11/15/11	07/22/13	0.00	45.00	0.00	0.00	0.00
TOTAL				0.00	45.00	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

Run Date: 09/24/2013  
Run Time: 17:50:29  
Page: 12

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	598.00	ADJUSTMENTS	0.00
COVERED CHARGES	598.00	CONTRACTUAL ALLOW	595.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MILLER COUNTY HOSPITAL  
 209 N CUTHBERT ST  
 COLQUITT,GA 39837-3518

PROVIDER NUMBER  
 000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	74.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	394.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	598.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	598.00	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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 17:50:30  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:50:36  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC  
 1201 SILOAM RD  
 GREENSBORO,GA 30642-2811

PROVIDER NUMBER 000001328A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	212,604.35	ADJUSTMENTS	0.00
COVERED CHARGES	188,933.15	CONTRACTUAL ALLOW	107,708.40
NON-COVERD CHARGES	23,671.20	TOTAL MEDICAID LIAB	81,224.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	81,224.75

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	71		0	46,150.00		19,950.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	71		0	46,150.00		19,950.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	71		0	46,150.00		19,950.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC  
 1201 SILOAM RD  
 GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,154.91	0.00	OTHER LAB	412.00	0.00
MED/SURG SUPPLY	4,857.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,914.69	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,219.76	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,247.08	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,039.40	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,854.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,630.18	0.00	PROFESSIONAL FEES	0.00	384.00
OPERATING ROOM	4,921.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,793.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	951.72	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,676.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,359.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	475.26	0.00	INJECTABLE DRUGS	27,245.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	978.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,337.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,236.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	816.84	0.00			
			TOTAL ANCILLARY	142,783.15	3,721.20
			TOTAL ACCOMODATIONS	46,150.00	19,950.00
			TOTAL CHARGES	188,933.15	23,671.20

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC  
1201 SILOAM RD  
GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
000001328A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 17:50:37  
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GOOD SAMARITAN HOSPITAL INC  
1201 SILOAM RD  
GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,021,321.19	ADJUSTMENTS	47,633.04
COVERED CHARGES	816,061.91	CONTRACTUAL ALLOW	453,440.13
NON-COVERD CHARGES	205,259.28	TOTAL MEDICAID LIAB	362,621.78
		LESS: COB	388.84
		LESS: COPAYMENT	1,041.00
		REIMBURSEMENT	361,191.94
		ALL OTHER	331,211.06
		FEE SCHEDULE-LAB	25,745.38
		INJECTABLE DRUGS	4,235.50

TOTAL NUMBER OF CLAIMS 974

GOOD SAMARITAN HOSPITAL INC  
 1201 SILOAM RD  
 GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,687.35	1,756.28	OTHER LAB	8,541.79	0.00
MED/SURG SUPPLY	21,253.09	502.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,571.75	199.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	102,380.43	97,496.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,735.56	4,859.59	FEE SCHEDULE LAB	183,395.54	44,516.31
EKG/ECG	9,888.00	309.00	MRI SERVICES	3,409.28	2,019.79
IV THERAPY	28,627.00	6,552.80	PROFESSIONAL FEES	0.00	772.60
OPERATING ROOM	83,618.16	13,452.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	250.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,094.25	1,643.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	20,686.41	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	153,650.49	2,046.72	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,466.68	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,723.99	5,824.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	123.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,457.85	878.79			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,472.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,632.58	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,082.52	1,741.76			
			TOTAL ANCILLARY	816,061.91	205,259.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	816,061.91	205,259.28

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 17:50:51  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC  
1201 SILOAM RD  
GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,608.45	ADJUSTMENTS	0.00
COVERED CHARGES	4,136.64	CONTRACTUAL ALLOW	-332.50
NON-COVERD CHARGES	4,471.81	TOTAL MEDICAID LIAB	4,469.14
		LESS: COB	4,468.81
		LESS: COPAYMENT	0.33
		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

GOOD SAMARITAN HOSPITAL INC  
 1201 SILOAM RD  
 GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	64.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,619.16	FEE SCHEDULE LAB	1,333.92	15.65
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	465.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,554.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	206.50	87.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,136.64	4,471.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,136.64	4,471.81

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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GOOD SAMARITAN HOSPITAL INC  
1201 SILOAM RD  
GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	108,693.91	ADJUSTMENTS	811.00
COVERED CHARGES	96,533.85	CONTRACTUAL ALLOW	86,891.21
NON-COVERD CHARGES	12,160.06	TOTAL MEDICAID LIAB	9,642.64
		LESS: COB	42.64
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	9,318.00
		TOTAL NUMBER OF CLAIMS	192

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC  
 1201 SILOAM RD  
 GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,192.12	112.52	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	907.53	57.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,759.80	131.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,826.32	7,040.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,231.36	2,862.12
EKG/ECG	772.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,869.52	308.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	273.00	189.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,278.11	486.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,124.28	217.34
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	951.43	292.93			
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	3,322.88	461.16			
			TOTAL ANCILLARY	96,533.85	12,160.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,533.85	12,160.06

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: 09/24/2013  
Run Time: 17:50:54  
Page: 10

GOOD SAMARITAN HOSPITAL INC  
1201 SILOAM RD  
GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
000001328A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 17:50:55  
Page: 11

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC  
1201 SILOAM RD  
GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,417.51	ADJUSTMENTS	0.00
COVERED CHARGES	11,395.75	CONTRACTUAL ALLOW	7,021.43
NON-COVERD CHARGES	1,021.76	TOTAL MEDICAID LIAB	4,374.32
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,371.32

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC  
 1201 SILOAM RD  
 GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	491.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,456.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	337.31	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,219.91	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	934.21	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	679.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	180.25	87.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	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	11,395.75	1,021.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,395.75	1,021.76

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 17:50:55  
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC  
1201 SILOAM RD  
GREENSBORO,GA 30642-2811

PROVIDER NUMBER  
000001328A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:51:01  
 Page: 1

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	204,864.05	ADJUSTMENTS	0.00
COVERED CHARGES	204,704.05	CONTRACTUAL ALLOW	105,123.90
NON-COVERD CHARGES	160.00	TOTAL MEDICAID LIAB	99,580.15
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	99,580.15
		TOTAL NUMBER OF ADMISSIONS	22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	69		0	37,329.00		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	69		0	37,329.00		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	69		0	37,329.00		160.00



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:51:01  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,727.05	0.00	OTHER LAB	1,148.00	0.00
MED/SURG SUPPLY	15,076.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,611.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,520.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,174.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,185.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	852.00	0.00	MRI SERVICES	2,509.00	0.00
IV THERAPY	364.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,283.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,420.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,525.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	764.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,682.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,174.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,361.00	0.00			
			TOTAL ANCILLARY	167,375.05	0.00
			TOTAL ACCOMODATIONS	37,329.00	160.00
			TOTAL CHARGES	204,704.05	160.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:51:02  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 17:51:03  
Page: 4

MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,890,632.87	ADJUSTMENTS	109,848.82
COVERED CHARGES	1,720,910.17	CONTRACTUAL ALLOW	1,237,727.43
NON-COVERD CHARGES	169,722.70	TOTAL MEDICAID LIAB	483,182.74
		LESS: COB	78.94
		LESS: COPAYMENT	1,935.00
		REIMBURSEMENT	481,168.80
		ALL OTHER	427,266.84
		FEE SCHEDULE-LAB	51,000.62
		INJECTABLE DRUGS	2,901.34
		TOTAL NUMBER OF CLAIMS	2,263

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,694.00	14,927.00	OTHER LAB	3,088.00	0.00
MED/SURG SUPPLY	29,761.00	54.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	98.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	119,395.00	184.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	267,504.00	33,975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	38,036.00	7,970.00	FEE SCHEDULE LAB	424,047.77	55,266.70
EKG/ECG	16,088.00	165.00	MRI SERVICES	37,351.00	1,577.00
IV THERAPY	137,199.00	7,345.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,818.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,592.00	7,290.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	281.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	379,548.00	541.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	33.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,185.40	26,590.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,149.00	6,369.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	938.00	3,626.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	15.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	204.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,204.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,886.00	1,160.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,864.00	1,856.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,216.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,346.00	196.00			
			TOTAL ANCILLARY	1,720,910.17	169,722.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,720,910.17	169,722.70

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: 09/24/2013  
Run Time: 17:51:24  
Page: 6

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,294.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,465.00	CONTRACTUAL ALLOW	-929.39
NON-COVERD CHARGES	5,829.00	TOTAL MEDICAID LIAB	15,394.39
		LESS: COB	15,385.42
		LESS: COPAYMENT	8.97
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55.00	163.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	456.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,257.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,016.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,179.00	1,303.00
EKG/ECG	142.00	10.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,398.00	695.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77.00	387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,400.00	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	183.00	255.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	316.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,002.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,465.00	5,829.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,465.00	5,829.00

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: 09/24/2013  
Run Time: 17:51:24  
Page: 8

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,985.00	ADJUSTMENTS	670.00
COVERED CHARGES	107,741.00	CONTRACTUAL ALLOW	98,241.00
NON-COVERD CHARGES	10,244.00	TOTAL MEDICAID LIAB	9,500.00
		LESS: COB	30.00
		LESS: COPAYMENT	339.03
		REIMBURSEMENT	9,130.97
		TOTAL NUMBER OF CLAIMS	190

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL  
 90 E STEPHENS ST  
 CAMILLA,GA 31730-1836

PROVIDER NUMBER  
 000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,182.00	368.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	784.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,104.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,427.00	5,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,288.00	2,068.00
EKG/ECG	852.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,267.00	391.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	409.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,335.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,247.00	237.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	491.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	632.00	1,580.00			
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	723.00	0.00			
			TOTAL ANCILLARY	107,741.00	10,244.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,741.00	10,244.00



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: 09/24/2013  
Run Time: 17:51:26  
Page: 10

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,694.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,694.00	CONTRACTUAL ALLOW	503.48
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,190.52
		LESS: COB	2,187.52
		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: 09/24/2013  
 Run Time: 17:51:26  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	289.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	500.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,258.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	632.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,694.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,694.00	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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	177,868.60	ADJUSTMENTS	12,896.31
COVERED CHARGES	177,013.60	CONTRACTUAL ALLOW	155,474.75
NON-COVERD CHARGES	855.00	TOTAL MEDICAID LIAB	21,538.85
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	21,490.85

TOTAL NUMBER OF CLAIMS 5

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,229.60	715.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,137.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	217.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,097.00	140.00
EKG/ECG	327.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,006.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	177,013.60	855.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	177,013.60	855.00

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: 09/24/2013  
Run Time: 17:51:28  
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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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:51:34  
 Page: 1

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	214,073.39	ADJUSTMENTS	2,494.49
COVERED CHARGES	212,739.39	CONTRACTUAL ALLOW	84,935.87
NON-COVERD CHARGES	1,334.00	TOTAL MEDICAID LIAB	127,803.52
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	127,803.52
TOTAL NUMBER OF ADMISSIONS			24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	60		0	27,270.00		630.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	60		0	27,270.00		630.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	6		0	5,448.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,448.00		0.00
TOTAL ACCOMODATIONS	66		0	32,718.00		630.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,499.47	0.00	OTHER LAB	992.00	0.00
MED/SURG SUPPLY	10,102.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	50,092.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,794.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,898.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	644.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,003.00	0.00	MRI SERVICES	11,522.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,457.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,516.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	57.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,807.00	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	3,778.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,778.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,252.00	704.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,682.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,146.00	0.00			
			TOTAL ANCILLARY	180,021.39	704.00
			TOTAL ACCOMODATIONS	32,718.00	630.00
			TOTAL CHARGES	212,739.39	1,334.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:51:35  
Page: 3

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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 17:51:35  
Page: 4

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	665,301.40	ADJUSTMENTS	3,595.48
COVERED CHARGES	582,774.64	CONTRACTUAL ALLOW	386,505.62
NON-COVERD CHARGES	82,526.76	TOTAL MEDICAID LIAB	196,269.02
		LESS: COB	699.94
		LESS: COPAYMENT	945.00
		REIMBURSEMENT	194,624.08
		ALL OTHER	178,282.68
		FEE SCHEDULE-LAB	15,903.27
		INJECTABLE DRUGS	438.13

TOTAL NUMBER OF CLAIMS 713

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,404.68	96.80	OTHER LAB	8,184.00	0.00
MED/SURG SUPPLY	4,182.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	129.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,758.00	1,235.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,443.00	23,682.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	624.00	0.00	FEE SCHEDULE LAB	133,020.16	27,881.26
EKG/ECG	7,867.00	1,569.00	MRI SERVICES	74,406.00	4,262.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,281.00	8,198.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,487.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	12,470.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	128,675.00	780.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,855.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,103.76	3.70
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	402.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	488.00
OTHER IMAGING SERVICE	19,155.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,268.00	1,732.00			
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	954.00	0.00			
			TOTAL ANCILLARY	582,774.64	82,526.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	582,774.64	82,526.76

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

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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3015	2212033004532	01/15/12 - 01/15/12	02/06/12	0.00	74.00	0.00	0.00	0.00
8006	2212033006445	01/04/12 - 01/04/12	02/06/12	0.00	99.00	0.00	0.00	0.00
3010	2212088009973	03/14/12 - 03/14/12	04/02/12	0.00	179.00	0.00	0.00	0.00
3014	2212292006628	09/11/12 - 09/11/12	10/22/12	0.00	136.00	0.00	0.00	0.00
TOTAL				0.00	488.00	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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,485.64	ADJUSTMENTS	0.00
COVERED CHARGES	3,984.64	CONTRACTUAL ALLOW	1,845.26
NON-COVERD CHARGES	501.00	TOTAL MEDICAID LIAB	2,139.38
		LESS: COB	2,135.65
		LESS: COPAYMENT	3.73
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59.18	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	74.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	850.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,119.00	241.00
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	1,716.00	260.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3.80	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	3,984.64	501.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,984.64	501.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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MONROE COUNTY HOSPITAL  
88 MARTIN LUTHER KING JR DR  
FORSYTH,GA 31029-1682

PROVIDER NUMBER  
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,593.42	ADJUSTMENTS	100.00
COVERED CHARGES	71,279.42	CONTRACTUAL ALLOW	62,529.42
NON-COVERD CHARGES	3,314.00	TOTAL MEDICAID LIAB	8,750.00
		LESS: COB	32.47
		LESS: COPAYMENT	303.00
		REIMBURSEMENT	8,414.53
		TOTAL NUMBER OF CLAIMS	175

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,861.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	295.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	59.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,398.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,353.00	1,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,824.00	1,598.00
EKG/ECG	810.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	74.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,582.00	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	493.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	189.00
OTHER IMAGING SERVICE	587.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	71,279.42	3,314.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	71,279.42	3,314.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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MONROE COUNTY HOSPITAL  
88 MARTIN LUTHER KING JR DR  
FORSYTH,GA 31029-1682

PROVIDER NUMBER  
000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3001	2212088013549	03/18/12 - 03/18/12	04/02/12	0.00	189.00	0.00	0.00	0.00
TOTAL				0.00	189.00	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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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,793.18	ADJUSTMENTS	0.00
COVERED CHARGES	1,774.18	CONTRACTUAL ALLOW	544.04
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	1,230.14
		LESS: COB	1,230.14
		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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	347.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	543.00	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	806.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,774.18	19.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,774.18	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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,816.42	ADJUSTMENTS	4,373.56
COVERED CHARGES	12,961.42	CONTRACTUAL ALLOW	8,578.86
NON-COVERD CHARGES	855.00	TOTAL MEDICAID LIAB	4,382.56
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	4,373.56

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	728.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	58.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	151.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,132.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,294.00	503.00
EKG/ECG	0.00	0.00	MRI SERVICES	4,262.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	11.20	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.	324.00	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	12,961.42	855.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,961.42	855.00

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: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:52:10  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 02/01/12 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,779.39	ADJUSTMENTS	0.00
COVERED CHARGES	57,742.25	CONTRACTUAL ALLOW	40,634.67
NON-COVERD CHARGES	1,037.14	TOTAL MEDICAID LIAB	17,107.58
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,107.58

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	8,690.00		440.00
ROUTINE NURSERY	0		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	8,690.00		440.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	8,690.00		440.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 02/01/12 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,295.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,795.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,619.51	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,243.75	0.00	OTHER THERAPEUTIC SVC	0.00	597.14
CT SCAN	5,454.53	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	636.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	605.32	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,102.34	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,613.42	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,464.98	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,204.47	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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	49,052.25	597.14
			TOTAL ACCOMODATIONS	8,690.00	440.00
			TOTAL CHARGES	57,742.25	1,037.14

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 02/01/12 THROUGH 03/31/12  
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: 09/24/2013  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 02/01/12 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	380,274.76	ADJUSTMENTS	36,059.87
COVERED CHARGES	315,082.41	CONTRACTUAL ALLOW	261,915.91
NON-COVERD CHARGES	65,192.35	TOTAL MEDICAID LIAB	53,166.50
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	53,037.50
		ALL OTHER	47,163.86
		FEE SCHEDULE-LAB	5,765.58
		INJECTABLE DRUGS	108.06

TOTAL NUMBER OF CLAIMS 199

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 17:52:10  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 02/01/12 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,430.55	2,613.70	OTHER LAB	1,175.59	0.00
MED/SURG SUPPLY	5,980.56	1,035.71	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,616.92	192.50	OTHER THERAPEUTIC SVC	0.00	5,766.34
CT SCAN	44,317.99	12,612.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	102,956.30	31,977.39
EKG/ECG	9,302.65	778.14	MRI SERVICES	11,910.30	3,970.10
IV THERAPY	16,968.38	791.54	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,019.67	1,807.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,001.98	1,470.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,378.27	1,347.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	519.22	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,077.79	828.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,426.24	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	315,082.41	65,192.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	315,082.41	65,192.35

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 02/01/12 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	598.13	ADJUSTMENTS	0.00
COVERED CHARGES	584.76	CONTRACTUAL ALLOW	471.13
NON-COVERD CHARGES	13.37	TOTAL MEDICAID LIAB	113.63
		LESS: COB	113.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 02/01/12 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 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	584.76	13.37
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	584.76	13.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	584.76	13.37

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 02/01/12 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,720.72	ADJUSTMENTS	2,047.72
COVERED CHARGES	40,653.48	CONTRACTUAL ALLOW	37,017.38
NON-COVERD CHARGES	1,067.24	TOTAL MEDICAID LIAB	3,636.10
		LESS: COB	0.00
		LESS: COPAYMENT	141.00
		REIMBURSEMENT	3,495.10

TOTAL NUMBER OF CLAIMS 65

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 02/01/12 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	712.78	65.30	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	99.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,806.07	0.00	OTHER THERAPEUTIC SVC	0.00	917.52
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,742.82	84.42
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,849.08	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,360.27	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	82.47	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	40,653.48	1,067.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,653.48	1,067.24

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	02/01/12	THROUGH	03/31/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	02/01/12	THROUGH	03/31/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	02/01/12	THROUGH	03/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 01/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,893.59	ADJUSTMENTS	0.00
COVERED CHARGES	104,610.85	CONTRACTUAL ALLOW	61,924.10
NON-COVERD CHARGES	1,282.74	TOTAL MEDICAID LIAB	42,686.75
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	42,686.75

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	19		0	16,511.00		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	19		0	16,511.00		836.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	16,511.00		836.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 01/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,594.15	0.00	OTHER LAB	1,424.59	0.00
MED/SURG SUPPLY	9,190.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,464.38	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,187.68	0.00	OTHER THERAPEUTIC SVC	0.00	446.74
CT SCAN	3,677.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,037.52	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,128.05	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,693.76	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,755.60	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	4,150.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	240.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,177.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	377.37	0.00			
			TOTAL ANCILLARY	88,099.85	446.74
			TOTAL ACCOMODATIONS	16,511.00	836.00
			TOTAL CHARGES	104,610.85	1,282.74

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	01/31/12
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: 09/24/2013  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 01/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	917,160.77	ADJUSTMENTS	5,575.44
COVERED CHARGES	802,415.38	CONTRACTUAL ALLOW	652,399.63
NON-COVERD CHARGES	114,745.39	TOTAL MEDICAID LIAB	150,015.75
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	149,910.75
		ALL OTHER	137,125.25
		FEE SCHEDULE-LAB	12,733.65
		INJECTABLE DRUGS	51.85

TOTAL NUMBER OF CLAIMS 464

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 01/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,190.65	357.20	OTHER LAB	5,815.70	0.00
MED/SURG SUPPLY	28,528.49	262.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,245.93	0.00	OTHER THERAPEUTIC SVC	0.00	4,224.18
CT SCAN	98,641.69	33,242.53	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	230,466.21	59,235.63
EKG/ECG	17,509.11	0.00	MRI SERVICES	30,978.84	1,377.36
IV THERAPY	49,876.26	11,681.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,809.24	1,213.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,441.88	2,172.84	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,898.18	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	163,180.50	479.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,783.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,543.50	80.35
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	419.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,842.26	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,407.51	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,256.20	0.00			
			TOTAL ANCILLARY	802,415.38	114,745.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	802,415.38	114,745.39

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 01/31/12  
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: 09/24/2013  
Run Time: 17:52:02  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 01/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,360.10	ADJUSTMENTS	52.94
COVERED CHARGES	112,449.84	CONTRACTUAL ALLOW	105,401.40
NON-COVERD CHARGES	3,910.26	TOTAL MEDICAID LIAB	7,048.44
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	6,766.44
		TOTAL NUMBER OF CLAIMS	126



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 01/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,412.30	80.55	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,086.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,758.18	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,021.89	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,824.46	3,362.05
EKG/ECG	778.14	0.00	MRI SERVICES	3,970.10	0.00
IV THERAPY	7,200.06	390.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	979.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,147.47	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	91.40	76.70
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	1,012.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	167.72	0.00			
			TOTAL ANCILLARY	112,449.84	3,910.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	112,449.84	3,910.26

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

Run Date: 09/24/2013  
Run Time: 17:52:03  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	01/31/12
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: 09/24/2013  
Run Time: 17:52:03  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	01/31/12
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: 09/24/2013  
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Page: 11

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	01/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:52:20  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER 000001394A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,763,886.72	ADJUSTMENTS	195,689.90
COVERED CHARGES	7,156,821.23	CONTRACTUAL ALLOW	4,197,465.34
NON-COVERD CHARGES	607,065.49	TOTAL MEDICAID LIAB	2,959,355.89
		LESS: COB	43,672.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,915,683.75

TOTAL NUMBER OF ADMISSIONS 469

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,036		4	570,226.65		14,813.05
ROUTINE NURSERY	395		0	214,855.02		488,483.78
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,431		4	785,081.67		503,296.83
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	207		0	254,488.43		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	207		0	254,488.43		0.00
TOTAL ACCOMODATIONS	1,638		4	1,039,570.10		503,296.83

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,085,754.99	0.00	OTHER LAB	45,585.62	0.00
MED/SURG SUPPLY	605,436.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,041,454.56	292.04	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,472.06	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	556,832.27	71,545.41	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	102,972.24	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	53,663.05	0.00	MRI SERVICES	56,795.93	0.00
IV THERAPY	102,708.21	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	488,620.30	19,530.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	64,693.48	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108,685.51	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,005.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	34,934.63	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	315,482.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	173,267.74	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	25,621.52	0.00	INJECTABLE DRUGS	182,412.05	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	6,247.26	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,064.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,349.81	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	440,570.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	87,684.76	738.73			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	133,649.05	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	44,853.97	11,662.00			
AUDIOLOGY	6,165.00	0.00			
CARDIOLOGY	192,756.01	0.00			
AMBULATORY SURGERY	12,453.61	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,233.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,825.18	0.00			
			TOTAL ANCILLARY	6,117,251.13	103,768.66
			TOTAL ACCOMODATIONS	1,039,570.10	503,296.83
			TOTAL CHARGES	7,156,821.23	607,065.49

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

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	371,218.73	ADJUSTMENTS	0.00
COVERED CHARGES	223,615.10	CONTRACTUAL ALLOW	132,228.16
NON-COVERD CHARGES	147,603.63	TOTAL MEDICAID LIAB	91,386.94
		LESS: COB	91,386.94
		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	1,687.29		0.00
ROUTINE NURSERY	89		0	49,984.89		145,477.92
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	92		0	51,672.18		145,477.92
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	92		0	51,672.18		145,477.92

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,931.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,127.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	51,956.27	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,611.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,803.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	791.73	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,503.17	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,285.88	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,946.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,125.71
OTHER IMAGING SERVICE	2,514.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,959.84	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	102.75	0.00			
CARDIOLOGY	1,409.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	171,942.92	2,125.71
			TOTAL ACCOMODATIONS	51,672.18	145,477.92
			TOTAL CHARGES	223,615.10	147,603.63



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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NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
727	2313045000014	09/06/12 - 11/30/12	02/18/13	0.00	2,125.71	0.00	76,225.49	0.00
TOTAL				0.00	2,125.71	0.00	76,225.49	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,759,604.98	ADJUSTMENTS	310,110.26
COVERED CHARGES	9,544,934.62	CONTRACTUAL ALLOW	7,600,230.14
NON-COVERD CHARGES	1,214,670.36	TOTAL MEDICAID LIAB	1,944,704.48
		LESS: COB	14,213.58
		LESS: COPAYMENT	4,954.19
		REIMBURSEMENT	1,925,536.71
		ALL OTHER	1,740,282.00
		FEE SCHEDULE-LAB	143,698.57
		INJECTABLE DRUGS	41,556.14

TOTAL NUMBER OF CLAIMS 5,286

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371,153.49	1,098.73	OTHER LAB	40,798.55	0.00
MED/SURG SUPPLY	438,079.11	2,329.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,907.36	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	416,633.18	16,317.01	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,625,004.43	212,252.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	67,000.69	25,695.39	FEE SCHEDULE LAB	1,641,113.47	555,566.13
EKG/ECG	93,397.34	7,094.08	MRI SERVICES	311,148.07	20,768.90
IV THERAPY	232,966.25	1,384.18	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	831,493.19	151,555.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	638.14	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,943.66	569.74	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,671.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,735.97	5,456.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,962,070.11	26,865.26	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	149,391.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	361,201.79	70,884.98
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	638.22	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	58,938.41	37.86
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	200.10
OTHER IMAGING SERVICE	294,758.39	52,654.74			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,286.63	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	62,616.04	29,970.08			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	122,303.86	26,976.72			
AMBULATORY SURGERY	135.20	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	76,466.96	661.67			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	313,988.93	2,784.13			
			TOTAL ANCILLARY	9,544,934.62	1,214,670.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,544,934.62	1,214,670.36

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: 09/24/2013  
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NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3605	2213015011977	04/25/12 - 04/25/12	01/21/13	0.00	67.06	0.00	0.00	0.00
-1	2313137000014	11/17/12 - 11/17/12	06/24/13	0.00	133.04	0.00	0.00	0.00
TOTAL				0.00	200.10	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	103,768.37	ADJUSTMENTS	0.00
COVERED CHARGES	74,232.61	CONTRACTUAL ALLOW	44,232.38
NON-COVERD CHARGES	29,535.76	TOTAL MEDICAID LIAB	30,000.23
		LESS: COB	29,988.23
		LESS: COPAYMENT	12.00
		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

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,914.41	0.00	OTHER LAB	700.89	0.00
MED/SURG SUPPLY	2,584.79	16.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	65.98	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,681.13	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,006.24	14,537.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,263.97	3,148.64
EKG/ECG	629.48	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,550.47	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	915.05	1,830.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,359.03	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,735.97	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,318.82	802.54	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,483.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	912.84	760.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	190.36	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	23.00
OTHER IMAGING SERVICE	3,270.77	6,424.74			
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	661.67	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,979.10	0.00			
			TOTAL ANCILLARY	74,232.61	29,535.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	74,232.61	29,535.76

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

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213042009528	12/24/12 - 12/25/12	02/18/13	0.00	23.00	0.00	344.07	0.00
TOTAL				0.00	23.00	0.00	344.07	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: 09/24/2013  
Run Time: 17:53:29  
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NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,044,913.27	ADJUSTMENTS	2,916.85
COVERED CHARGES	956,949.15	CONTRACTUAL ALLOW	902,962.55
NON-COVERD CHARGES	87,964.12	TOTAL MEDICAID LIAB	53,986.60
		LESS: COB	30.00
		LESS: COPAYMENT	1,779.07
		REIMBURSEMENT	52,177.53
		TOTAL NUMBER OF CLAIMS	971



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,545.75	200.58	OTHER LAB	7,531.21	0.00
MED/SURG SUPPLY	16,548.83	253.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	309.34	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,502.18	214.16	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,856.06	7,923.76	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	195,367.88	72,271.72
EKG/ECG	7,711.13	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	20,234.12	204.78	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,510.16	571.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	853.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	488,115.31	1,239.28	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,082.68	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,009.17	1,988.40
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	16,735.68	2,787.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,877.66	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,468.21	0.00			
			TOTAL ANCILLARY	956,949.15	87,964.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	956,949.15	87,964.12

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,674.19	ADJUSTMENTS	0.00
COVERED CHARGES	30,358.72	CONTRACTUAL ALLOW	21,855.39
NON-COVERD CHARGES	12,315.47	TOTAL MEDICAID LIAB	8,503.33
		LESS: COB	8,470.33
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	24

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,718.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	769.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	196.86	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,422.29	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,932.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,844.30	2,483.38
EKG/ECG	944.22	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,491.56	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,029.43	576.50	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	384.25	23.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	754.96	1,103.24			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,358.72	12,315.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,358.72	12,315.47

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: 09/24/2013  
Run Time: 17:53:40  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,423.74	ADJUSTMENTS	9,937.36
COVERED CHARGES	137,530.88	CONTRACTUAL ALLOW	107,709.80
NON-COVERD CHARGES	4,892.86	TOTAL MEDICAID LIAB	29,821.08
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	29,809.08
		TOTAL NUMBER OF CLAIMS	6

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,072.48	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,205.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	995.07	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	407.77	FEE SCHEDULE LAB	611.11	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,088.06	3,900.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	553.78	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,468.67	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,541.28	584.30
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	51,708.81	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,226.18	0.00			
			TOTAL ANCILLARY	137,530.88	4,892.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	137,530.88	4,892.86

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 17:53:42  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL  
 1000 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1606

PROVIDER NUMBER 000001405A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,898,760.26	ADJUSTMENTS	12,228,910.99
COVERED CHARGES	74,453,719.81	CONTRACTUAL ALLOW	54,281,593.68
NON-COVERD CHARGES	3,445,040.45	TOTAL MEDICAID LIAB	20,172,126.13
		LESS: COB	556,579.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,615,546.17

TOTAL NUMBER OF ADMISSIONS 3,493

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,068		7	6,279,881.00		570,583.00
ROUTINE NURSERY	5,811		4	7,338,144.00		1,635,018.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12,879		11	13,618,025.00		2,205,601.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,765		0	5,299,730.00		0.00
NICU	556		0	2,640,631.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,321		0	7,940,361.00		0.00
TOTAL ACCOMODATIONS	15,200		11	21,558,386.00		2,205,601.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,797,849.36	114,850.95	OTHER LAB	247,878.00	1,042.00
MED/SURG SUPPLY	3,037,677.00	87,775.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,084,888.15	43,833.00	EDUCATION & TRAINING	6,978.00	520.00
RADIOLOGY-DIAGNOSTIC	824,897.00	718.00	OTHER THERAPEUTIC SVC	0.00	56,757.00
CT SCAN	1,169,279.00	2,073.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	423,351.00	770.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	150,750.00	516.00	MRI SERVICES	649,565.00	1,508.00
IV THERAPY	140,342.00	8,242.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,605,303.00	114,028.00	DURABLE MED. EQUIP.	0.00	142.00
LABOR/DELIVERY ROOM	4,432,278.00	14,524.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,633,300.00	5,471.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	603,717.00	2,202.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	934,299.00	41,706.00	SPECIAL SERVICES	0.00	12,004.00
RECOVERY ROOM	590,901.00	3,070.00	DRUG-SPECIFIC/HOME IV	0.00	18,863.00
LABORATORY PATHOLOGIC	719,673.00	0.00	INJECTABLE DRUGS	15,737,720.30	75,876.50
RADIOLOGY THERAPEUTIC	133,331.00	760.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	325,968.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	157,756.00	2,568.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	209,267.00	3,462.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	475,006.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	421,975.00	56,471.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,099,670.00	556,925.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	132,234.00	9,210.00			
AUDIOLOGY	361,289.00	0.00			
CARDIOLOGY	685,407.00	3,552.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	61,102.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,593.00	0.00			
			TOTAL ANCILLARY	52,895,333.81	1,239,439.45
			TOTAL ACCOMODATIONS	21,558,386.00	2,205,601.00
			TOTAL CHARGES	74,453,719.81	3,445,040.45



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:54:45  
 Page: 3

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,490,938.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,092,397.00	CONTRACTUAL ALLOW	2,852,708.07
NON-COVERD CHARGES	398,541.00	TOTAL MEDICAID LIAB	3,239,688.93
		LESS: COB	3,239,688.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 127

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	336		0	296,916.00		59,132.00
ROUTINE NURSERY	442		0	927,202.00		317,442.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	778		0	1,224,118.00		376,574.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	182		0	513,644.00		0.00
NICU	231		0	1,096,252.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	413		0	1,609,896.00		0.00
TOTAL ACCOMODATIONS	1,191		0	2,834,014.00		376,574.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	275,249.50	0.00	OTHER LAB	51,101.00	0.00
MED/SURG SUPPLY	210,282.50	251.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	386,718.00	0.00	EDUCATION & TRAINING	845.00	0.00
RADIOLOGY-DIAGNOSTIC	92,885.00	0.00	OTHER THERAPEUTIC SVC	264.00	2,522.00
CT SCAN	26,725.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,706.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,870.00	0.00	MRI SERVICES	26,553.00	0.00
IV THERAPY	1,920.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	220,918.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	230,998.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	408,053.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,836.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,474.00	0.00	SPECIAL SERVICES	0.00	19,194.00
RECOVERY ROOM	32,874.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	20,693.00	0.00	INJECTABLE DRUGS	859,281.00	0.00
RADIOLOGY THERAPEUTIC	45,898.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,294.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,897.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	41,351.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54,646.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	23,743.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,504.00	0.00			
AUDIOLOGY	20,720.00	0.00			
CARDIOLOGY	64,362.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,583.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139.00	0.00			
			TOTAL ANCILLARY	3,258,383.00	21,967.00
			TOTAL ACCOMODATIONS	2,834,014.00	376,574.00
			TOTAL CHARGES	6,092,397.00	398,541.00

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: 09/24/2013  
Run Time: 17:54:49  
Page: 5

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,778,380.65	ADJUSTMENTS	859,584.89
COVERED CHARGES	15,049,316.79	CONTRACTUAL ALLOW	11,968,608.86
NON-COVERD CHARGES	1,729,063.86	TOTAL MEDICAID LIAB	3,080,707.93
		LESS: COB	28,142.60
		LESS: COPAYMENT	7,779.66
		REIMBURSEMENT	3,044,785.67
		ALL OTHER	2,679,106.43
		FEE SCHEDULE-LAB	207,729.67
		INJECTABLE DRUGS	157,949.57

TOTAL NUMBER OF CLAIMS 5,335

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	632,174.80	13,060.50	OTHER LAB	64,654.00	0.00
MED/SURG SUPPLY	581,935.50	3,218.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	296.00	EDUCATION & TRAINING	10,458.00	1,538.00
RADIOLOGY-DIAGNOSTIC	326,759.00	6,917.00	OTHER THERAPEUTIC SVC	0.00	18,104.00
CT SCAN	723,766.00	36,135.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,998.00	10,541.00	FEE SCHEDULE LAB	2,897,346.99	346,511.55
EKG/ECG	90,603.00	2,322.00	MRI SERVICES	380,111.00	30,825.00
IV THERAPY	590,229.50	72,648.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,557,849.00	196,188.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	206,556.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,737.00	67.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	352,183.00	11,550.00	AMBULANCE	0.00	0.00
GI SERVICES	32,874.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,359,833.00	88,793.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	356,491.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,509.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,304,265.00	623,085.00
RADIOLOGY THERAPEUTIC	158,535.00	17,667.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,708.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	857.00	2,648.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,433.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	594.00	1,560.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	105,378.00	3,317.00	IMPL DEV CHARGE PATIENTS	125,150.00	9,276.00
LITHOTRIPSY	36,592.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,333,105.00	150,160.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	308,391.00	32,877.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	75,699.00	12,467.00			
AUDIOLOGY	3,193.00	1,170.00			
CARDIOLOGY	102,996.00	10,944.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,208.00	604.00			
ORGAN ACQUISITION	0.00	5,049.81			
TREATMENT/OBSERV. RM	300,795.00	1,875.00			
			TOTAL ANCILLARY	15,049,316.79	1,729,063.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,049,316.79	1,729,063.86

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL  
1000 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1606

PROVIDER NUMBER  
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	872,297.50	ADJUSTMENTS	0.00
COVERED CHARGES	685,584.50	CONTRACTUAL ALLOW	307,622.68
NON-COVERD CHARGES	186,713.00	TOTAL MEDICAID LIAB	377,961.82
		LESS: COB	377,451.50
		LESS: COPAYMENT	510.32
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 274

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,662.00	1,495.50	OTHER LAB	10,579.00	0.00
MED/SURG SUPPLY	32,585.00	2,535.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,288.00	812.00
RADIOLOGY-DIAGNOSTIC	11,938.00	316.00	OTHER THERAPEUTIC SVC	0.00	1,606.00
CT SCAN	23,813.00	12,667.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	482.00	FEE SCHEDULE LAB	109,986.00	29,767.00
EKG/ECG	1,290.00	0.00	MRI SERVICES	13,700.00	0.00
IV THERAPY	15,106.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	86,406.00	81,131.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,409.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	559.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	39,530.00	1,050.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,563.00	2,365.00	SPECIAL SERVICES	0.00	232.00
RECOVERY ROOM	34,162.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,848.50	9,775.50
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	408.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	28,558.00	0.00	IMPL DEV CHARGE PATIENTS	8,510.00	1,449.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	89,421.00	39,815.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,329.00	610.00			
AUDIOLOGY	365.00	327.00			
CARDIOLOGY	593.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,329.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,647.00	278.00			
			TOTAL ANCILLARY	685,584.50	186,713.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	685,584.50	186,713.00

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: 09/24/2013  
Run Time: 17:56:03  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	548,576.30	ADJUSTMENTS	1,609.17
COVERED CHARGES	505,707.80	CONTRACTUAL ALLOW	489,876.82
NON-COVERD CHARGES	42,868.50	TOTAL MEDICAID LIAB	15,830.98
		LESS: COB	0.00
		LESS: COPAYMENT	540.01
		REIMBURSEMENT	15,290.97
		TOTAL NUMBER OF CLAIMS	283

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,567.80	458.50	OTHER LAB	1,042.00	0.00
MED/SURG SUPPLY	7,839.00	433.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,508.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,715.00	2,073.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	80,709.00	9,816.00
EKG/ECG	5,160.00	258.00	MRI SERVICES	11,847.00	3,425.00
IV THERAPY	6,045.00	855.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,079.00	2,457.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,616.00	525.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	256,364.00	6,770.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,414.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,653.00	8,081.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,462.00	7,089.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	902.00	628.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,785.00	0.00			
			TOTAL ANCILLARY	505,707.80	42,868.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	505,707.80	42,868.50



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,531.50	ADJUSTMENTS	0.00
COVERED CHARGES	25,564.50	CONTRACTUAL ALLOW	18,846.28
NON-COVERD CHARGES	1,967.00	TOTAL MEDICAID LIAB	6,718.22
		LESS: COB	6,700.22
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,364.00	0.00	OTHER LAB	660.00	0.00
MED/SURG SUPPLY	275.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	755.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,531.00	739.00
EKG/ECG	258.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,514.00	285.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	487.50	241.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,720.00	702.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,564.50	1,967.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,564.50	1,967.00

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,785,747.90	ADJUSTMENTS	223,537.69
COVERED CHARGES	3,461,625.40	CONTRACTUAL ALLOW	2,918,309.41
NON-COVERD CHARGES	324,122.50	TOTAL MEDICAID LIAB	543,315.99
		LESS: COB	17,459.60
		LESS: COPAYMENT	798.00
		REIMBURSEMENT	525,058.39
		TOTAL NUMBER OF CLAIMS	105

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247,841.80	1,876.00	OTHER LAB	1,634.00	0.00
MED/SURG SUPPLY	185,248.00	27,587.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,814.00	1,452.00	OTHER THERAPEUTIC SVC	0.00	5,694.00
CT SCAN	39,252.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	338.00	FEE SCHEDULE LAB	241,402.20	22,782.00
EKG/ECG	7,224.00	1,032.00	MRI SERVICES	11,061.00	4,211.00
IV THERAPY	146,823.00	13,926.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	532,551.00	76,049.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	2,371.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,008.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,763.00	318.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,931.00	2,325.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,245.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,024.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	921,614.40	86,494.50
RADIOLOGY THERAPEUTIC	122,888.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	476.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	597.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,838.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30.00	60.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	500,984.00	27,934.00
LITHOTRIPSY	73,184.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,912.00	1,404.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	138,659.00	28,698.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,584.00	1,002.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	49,691.00	10,944.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	604.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	42,677.00	1,690.00			
			TOTAL ANCILLARY	3,461,625.40	324,122.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,461,625.40	324,122.50

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,062.00	ADJUSTMENTS	0.00
COVERED CHARGES	22,856.00	CONTRACTUAL ALLOW	-9,884.41
NON-COVERD CHARGES	28,206.00	TOTAL MEDICAID LIAB	32,740.41
		LESS: COB	32,722.41
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,716.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	693.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	438.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,168.00	23.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,841.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	28,183.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,856.00	28,206.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,856.00	28,206.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
 2000 PALMYRA RD  
 ALBANY,GA 31702-1528

PROVIDER NUMBER 000001416A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/16/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,532,858.21	ADJUSTMENTS	0.00
COVERED CHARGES	4,468,839.21	CONTRACTUAL ALLOW	3,090,848.35
NON-COVERD CHARGES	64,019.00	TOTAL MEDICAID LIAB	1,377,990.86
		LESS: COB	7,669.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,370,321.85

TOTAL NUMBER OF ADMISSIONS 152

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	662		0	362,308.00		13,046.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	662		0	362,308.00		13,046.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	185		0	248,455.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	185		0	248,455.00		0.00
TOTAL ACCOMODATIONS	847		0	610,763.00		13,046.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:56:21  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
 2000 PALMYRA RD  
 ALBANY,GA 31702-1528

PROVIDER NUMBER  
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/16/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	623,719.44	0.00	OTHER LAB	15,803.50	0.00
MED/SURG SUPPLY	182,252.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	720,738.52	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	133,899.50	0.00	OTHER THERAPEUTIC SVC	0.00	807.50
CT SCAN	188,890.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,990.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,026.50	0.00	MRI SERVICES	52,346.50	0.00
IV THERAPY	5,098.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	185,674.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	244,430.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	43,090.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	45,526.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	325,124.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,480.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	40,395.00
LABORATORY PATHOLOGIC	16,613.00	0.00	INJECTABLE DRUGS	729,997.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,837.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,020.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	53,295.00	5,652.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	522.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	87,016.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	28,755.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	42,368.00	2,265.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,120.50	1,853.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,020.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,318.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,102.00	0.00			
			TOTAL ANCILLARY	3,858,076.21	50,973.00
			TOTAL ACCOMODATIONS	610,763.00	13,046.00
			TOTAL CHARGES	4,468,839.21	64,019.00



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 PUTNEY MEMORIAL HOSPITAL, INC  
2000 PALMYRA RD  
ALBANY,GA 31702-1528

PROVIDER NUMBER  
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	12/16/11	THROUGH	07/31/12
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: 09/24/2013  
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PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
2000 PALMYRA RD  
ALBANY,GA 31702-1528

PROVIDER NUMBER  
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/16/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,897,456.57	ADJUSTMENTS	120,254.77
COVERED CHARGES	5,458,444.77	CONTRACTUAL ALLOW	4,304,972.44
NON-COVERD CHARGES	439,011.80	TOTAL MEDICAID LIAB	1,153,472.33
		LESS: COB	0.00
		LESS: COPAYMENT	951.00
		REIMBURSEMENT	1,152,521.33
		ALL OTHER	1,046,949.61
		FEE SCHEDULE-LAB	63,549.33
		INJECTABLE DRUGS	42,022.39
		TOTAL NUMBER OF CLAIMS	2,028

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
 2000 PALMYRA RD  
 ALBANY,GA 31702-1528

PROVIDER NUMBER  
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/16/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	245,013.50	0.00	OTHER LAB	5,447.50	0.00
MED/SURG SUPPLY	179,104.42	1,282.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	462,967.50	3,522.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	554,305.50	21,305.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	279.50	FEE SCHEDULE LAB	556,934.50	40,127.50
EKG/ECG	55,341.00	387.00	MRI SERVICES	7,859.00	3,195.00
IV THERAPY	135,937.50	5,994.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	580,838.40	76,553.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,167.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	191,637.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	150,603.00	15,294.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,586,844.50	138,459.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	266,866.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	219,503.95	66,710.75
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	1,716.00	760.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,385.00	46,509.00
LITHOTRIPSY	136,050.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,255.00	4,804.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	246.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,524.50	13,828.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,690.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,636.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,572.00	0.00			
			TOTAL ANCILLARY	5,458,444.77	439,011.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,458,444.77	439,011.80

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
2000 PALMYRA RD  
ALBANY,GA 31702-1528

PROVIDER NUMBER  
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/16/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,992.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,785.50	CONTRACTUAL ALLOW	3,051.91
NON-COVERD CHARGES	2,206.50	TOTAL MEDICAID LIAB	3,733.59
		LESS: COB	3,727.70
		LESS: COPAYMENT	5.89
		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

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
 2000 PALMYRA RD  
 ALBANY,GA 31702-1528

PROVIDER NUMBER  
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/16/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212.50	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	788.50	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	425.00	FEE SCHEDULE LAB	1,345.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	554.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,844.00	743.00	SPECIAL SERVICES	0.00	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	417.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	370.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	251.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,785.50	2,206.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,785.50	2,206.50

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: 09/24/2013  
Run Time: 17:56:48  
Page: 8

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
2000 PALMYRA RD  
ALBANY,GA 31702-1528

PROVIDER NUMBER  
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/16/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	584,820.00	ADJUSTMENTS	967.92
COVERED CHARGES	560,753.00	CONTRACTUAL ALLOW	536,307.22
NON-COVERD CHARGES	24,067.00	TOTAL MEDICAID LIAB	24,445.78
		LESS: COB	0.00
		LESS: COPAYMENT	858.00
		REIMBURSEMENT	23,587.78
		TOTAL NUMBER OF CLAIMS	437

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
 2000 PALMYRA RD  
 ALBANY,GA 31702-1528

PROVIDER NUMBER  
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/16/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,428.50	0.00	OTHER LAB	1,038.00	0.00
MED/SURG SUPPLY	4,146.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,590.50	376.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,028.00	4,327.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	63,616.50	10,890.00
EKG/ECG	2,515.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,616.50	315.50	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	832.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	374,110.00	3,425.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,439.00	3,272.50
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	13,775.50	251.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,617.00	1,210.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	560,753.00	24,067.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	560,753.00	24,067.00

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: 09/24/2013  
Run Time: 17:56:52  
Page: 10

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
2000 PALMYRA RD  
ALBANY,GA 31702-1528

PROVIDER NUMBER  
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	12/16/11	THROUGH	07/31/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
2000 PALMYRA RD  
ALBANY,GA 31702-1528

PROVIDER NUMBER  
000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/16/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	221,728.09	ADJUSTMENTS	10,794.94
COVERED CHARGES	211,279.66	CONTRACTUAL ALLOW	173,455.37
NON-COVERD CHARGES	10,448.43	TOTAL MEDICAID LIAB	37,824.29
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	37,794.29

TOTAL NUMBER OF CLAIMS 7

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
 2000 PALMYRA RD  
 ALBANY,GA 31702-1528

PROVIDER NUMBER  
 000001416A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/16/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,571.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,800.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,058.00	705.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	279.50	FEE SCHEDULE LAB	2,581.00	180.00
EKG/ECG	580.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,971.06	5,209.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,214.50	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	11,854.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,390.50	4,074.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,301.00	0.00
LITHOTRIPSY	13,605.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	352.00	0.00			
			TOTAL ANCILLARY	211,279.66	10,448.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	211,279.66	10,448.43

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC  
2000 PALMYRA RD  
ALBANY,GA 31702-1528

PROVIDER NUMBER  
000001416A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	12/16/11	THROUGH	07/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:57:00  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	238,149.41	ADJUSTMENTS	15,478.40
COVERED CHARGES	234,333.41	CONTRACTUAL ALLOW	113,363.54
NON-COVERD CHARGES	3,816.00	TOTAL MEDICAID LIAB	120,969.87
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	120,969.87

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	81		0	38,643.00		2,116.00
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	81		0	38,643.00		2,116.00
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	81		0	38,643.00		2,116.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,568.01	0.00	OTHER LAB	802.00	0.00
MED/SURG SUPPLY	17,518.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	37,416.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,996.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	362.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,005.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,353.00	0.00	PROFESSIONAL FEES	0.00	809.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,168.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,427.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,405.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	488.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,882.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,059.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,130.00	754.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,887.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,974.40	0.00			
			TOTAL ANCILLARY	195,690.41	1,700.00
			TOTAL ACCOMODATIONS	38,643.00	2,116.00
			TOTAL CHARGES	234,333.41	3,816.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 07/31/12  
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: 09/24/2013  
Run Time: 17:57:00  
Page: 4

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	933,456.67	ADJUSTMENTS	11,360.27
COVERED CHARGES	815,456.87	CONTRACTUAL ALLOW	581,245.64
NON-COVERD CHARGES	117,999.80	TOTAL MEDICAID LIAB	234,211.23
		LESS: COB	0.00
		LESS: COPAYMENT	732.00
		REIMBURSEMENT	233,479.23
		ALL OTHER	198,020.75
		FEE SCHEDULE-LAB	34,054.30
		INJECTABLE DRUGS	1,404.18
		TOTAL NUMBER OF CLAIMS	1,091

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 17:57:00  
 Page: 5

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,417.30	1,078.00	OTHER LAB	4,990.00	0.00
MED/SURG SUPPLY	28,289.37	720.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,086.10	313.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,604.00	23,281.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,015.00	417.00	FEE SCHEDULE LAB	239,765.00	71,709.80
EKG/ECG	8,995.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,224.00	198.00	PROFESSIONAL FEES	0.00	511.00
OPERATING ROOM	20,366.00	3,890.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,871.00	769.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,770.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	60.00	0.00
EMERGENCY ROOM	198,450.00	474.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,972.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,990.75	1,071.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,819.00	6,247.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,977.00	2,079.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,172.00	432.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,747.00	1,523.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,044.00	636.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,753.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	31,554.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,525.00	2,651.00			
			TOTAL ANCILLARY	815,456.87	117,999.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	815,456.87	117,999.80



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

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,673.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,422.00	CONTRACTUAL ALLOW	2,270.77
NON-COVERD CHARGES	251.00	TOTAL MEDICAID LIAB	151.23
		LESS: COB	148.23
		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

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	69.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	851.00	251.00
EKG/ECG	105.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	146.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	643.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,422.00	251.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,422.00	251.00

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: 09/24/2013  
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SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	136,358.87	ADJUSTMENTS	123.00
COVERED CHARGES	133,069.37	CONTRACTUAL ALLOW	122,891.94
NON-COVERD CHARGES	3,289.50	TOTAL MEDICAID LIAB	10,177.43
		LESS: COB	0.00
		LESS: COPAYMENT	480.00
		REIMBURSEMENT	9,697.43
		TOTAL NUMBER OF CLAIMS	232

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,340.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,789.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,331.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,452.00	1,685.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,174.00	1,080.00
EKG/ECG	420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	408.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	248.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,484.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	97,127.37	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,233.00	116.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,240.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	231.00	0.00			
			TOTAL ANCILLARY	133,069.37	3,289.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	133,069.37	3,289.50

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: 09/24/2013  
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SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	294.00	ADJUSTMENTS	0.00
COVERED CHARGES	294.00	CONTRACTUAL ALLOW	162.32
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	131.68
		LESS: COB	131.68
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 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	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	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	294.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	294.00	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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
000001427A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	07/31/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6200

PROVIDER NUMBER  
000001427A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	07/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:57:20  
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WELLSTAR PAULDING HOSPITAL  
 600 W MEMORIAL DR  
 DALLAS,GA 30132-4117

PROVIDER NUMBER 000001438A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,950,050.76	ADJUSTMENTS	144,814.38
COVERED CHARGES	3,925,513.76	CONTRACTUAL ALLOW	2,719,531.13
NON-COVERD CHARGES	24,537.00	TOTAL MEDICAID LIAB	1,205,982.63
		LESS: COB	3,602.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,202,380.04

TOTAL NUMBER OF ADMISSIONS 158

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	370		1	375,180.00		4,764.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	370		1	375,180.00		4,764.00
SPECIAL CARE SERVICES						
CCU	153		0	216,186.00		0.00
ICU	70		0	162,470.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	223		0	378,656.00		0.00
TOTAL ACCOMODATIONS	593		1	753,836.00		4,764.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL  
 600 W MEMORIAL DR  
 DALLAS,GA 30132-4117

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	583,938.03	0.00	OTHER LAB	21,286.00	0.00
MED/SURG SUPPLY	161,295.00	307.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	640,189.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	108,823.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	403,240.00	1,463.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,911.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,042.00	0.00	MRI SERVICES	44,778.00	0.00
IV THERAPY	110,862.00	7,660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	170,984.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	327,380.00	324.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	75,359.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	235,932.00	174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,844.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,846.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	17,513.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	281.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,504.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	792.00	6,131.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,776.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,539.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,875.00	2,519.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,715.00	1,021.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	79,968.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,005.23	174.00			
			TOTAL ANCILLARY	3,171,677.76	19,773.00
			TOTAL ACCOMODATIONS	753,836.00	4,764.00
			TOTAL CHARGES	3,925,513.76	24,537.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:57:25  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL  
600 W MEMORIAL DR  
DALLAS,GA 30132-4117

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 17:57:26  
Page: 4

WELLSTAR PAULDING HOSPITAL  
600 W MEMORIAL DR  
DALLAS,GA 30132-4117

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,889,041.18	ADJUSTMENTS	158,497.94
COVERED CHARGES	7,537,274.38	CONTRACTUAL ALLOW	6,020,299.68
NON-COVERD CHARGES	351,766.80	TOTAL MEDICAID LIAB	1,516,974.70
		LESS: COB	17,266.46
		LESS: COPAYMENT	2,772.90
		REIMBURSEMENT	1,496,935.34
		ALL OTHER	1,398,531.68
		FEE SCHEDULE-LAB	77,639.61
		INJECTABLE DRUGS	20,764.05

TOTAL NUMBER OF CLAIMS 3,132

WELLSTAR PAULDING HOSPITAL  
 600 W MEMORIAL DR  
 DALLAS,GA 30132-4117

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253,218.56	1,650.00	OTHER LAB	60,092.00	1,806.00
MED/SURG SUPPLY	58,967.00	535.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	451,055.00	7,385.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,446,563.00	100,490.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,169,680.70	154,847.30
EKG/ECG	109,191.00	538.00	MRI SERVICES	441,285.00	17,029.00
IV THERAPY	317,876.00	732.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	136,745.00	7,501.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	1,255.00	0.00
RESPIRATORY SERVICES	77,237.00	15,970.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,002.00	1,696.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,013,299.00	5,933.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,746.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	88,149.25	10,345.50
RADIOLOGY THERAPEUTIC	238,865.00	737.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,710.00	3,358.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,051.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	224,059.00	15,467.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,933.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,467.00	5,747.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	121,696.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,996.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	76,135.87	0.00			
			TOTAL ANCILLARY	7,537,274.38	351,766.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,537,274.38	351,766.80

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL  
600 W MEMORIAL DR  
DALLAS,GA 30132-4117

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	217,113.52	ADJUSTMENTS	0.00
COVERED CHARGES	187,756.77	CONTRACTUAL ALLOW	56,686.05
NON-COVERD CHARGES	29,356.75	TOTAL MEDICAID LIAB	131,070.72
		LESS: COB	131,050.25
		LESS: COPAYMENT	20.47
		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 PAULDING HOSPITAL  
 600 W MEMORIAL DR  
 DALLAS,GA 30132-4117

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,699.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,489.00	43.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,869.00	11,383.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,741.00	4,016.00
EKG/ECG	3,419.00	0.00	MRI SERVICES	18,029.00	6,710.00
IV THERAPY	8,243.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,826.00	2,826.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,381.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,938.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,245.00	484.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,748.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	83.25	196.75
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	144.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	132.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,630.00	3,554.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,785.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	334.52	0.00			
			TOTAL ANCILLARY	187,756.77	29,356.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	187,756.77	29,356.75

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: 09/24/2013  
Run Time: 17:57:54  
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WELLSTAR PAULDING HOSPITAL  
600 W MEMORIAL DR  
DALLAS,GA 30132-4117

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	692,547.75	ADJUSTMENTS	544.40
COVERED CHARGES	679,367.00	CONTRACTUAL ALLOW	649,505.98
NON-COVERD CHARGES	13,180.75	TOTAL MEDICAID LIAB	29,861.02
		LESS: COB	0.00
		LESS: COPAYMENT	936.00
		REIMBURSEMENT	28,925.02
		TOTAL NUMBER OF CLAIMS	534



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL  
 600 W MEMORIAL DR  
 DALLAS,GA 30132-4117

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,136.25	344.75	OTHER LAB	2,512.00	903.00
MED/SURG SUPPLY	2,761.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,248.00	1,078.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,427.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	132,685.00	8,114.00
EKG/ECG	6,994.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,941.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,866.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	424.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	357,191.00	320.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	724.75	0.00
RADIOLOGY THERAPEUTIC	2,796.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,085.00	1,997.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	679,367.00	13,180.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	679,367.00	13,180.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 17:57:59  
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WELLSTAR PAULDING HOSPITAL  
600 W MEMORIAL DR  
DALLAS,GA 30132-4117

PROVIDER NUMBER  
000001438A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,649.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,851.00	CONTRACTUAL ALLOW	4,252.48
NON-COVERD CHARGES	798.00	TOTAL MEDICAID LIAB	9,598.52
		LESS: COB	9,589.52
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:57:59  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL  
 600 W MEMORIAL DR  
 DALLAS,GA 30132-4117

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	289.00	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	440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,003.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	181.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,304.00	29.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	769.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,851.00	798.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,851.00	798.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL  
600 W MEMORIAL DR  
DALLAS,GA 30132-4117

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	353,305.24	ADJUSTMENTS	10,430.38
COVERED CHARGES	348,089.24	CONTRACTUAL ALLOW	306,367.72
NON-COVERD CHARGES	5,216.00	TOTAL MEDICAID LIAB	41,721.52
		LESS: COB	0.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	41,541.52
		TOTAL NUMBER OF CLAIMS	8

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL  
 600 W MEMORIAL DR  
 DALLAS,GA 30132-4117

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,684.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	316.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,067.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,111.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,665.00	1,376.00
EKG/ECG	915.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	472.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,945.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,283.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	876.25	0.00
RADIOLOGY THERAPEUTIC	260,162.00	3,840.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	839.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,132.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,353.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,268.99	0.00			
			TOTAL ANCILLARY	348,089.24	5,216.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	348,089.24	5,216.00

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: 09/24/2013  
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Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL  
600 W MEMORIAL DR  
DALLAS,GA 30132-4117

PROVIDER NUMBER  
000001438A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:58:07  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER 000001449A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/01/11 THROUGH 10/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	462,985.00	ADJUSTMENTS	5,549.43
COVERED CHARGES	458,273.00	CONTRACTUAL ALLOW	183,847.77
NON-COVERD CHARGES	4,712.00	TOTAL MEDICAID LIAB	274,425.23
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	274,425.23

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	190		0	68,400.00		1,800.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	190		0	68,400.00		1,800.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	190		0	68,400.00		1,800.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 17:58:07  
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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 11/01/11 THROUGH 10/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	122,894.00	0.00	OTHER LAB	2,094.00	0.00
MED/SURG SUPPLY	26,914.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	114,748.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,115.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,114.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,238.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,025.00	0.00	MRI SERVICES	1,297.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,991.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,765.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,710.00	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	11,254.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,722.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	480.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,132.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,844.00	2,912.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,016.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	389,873.00	2,912.00
			TOTAL ACCOMODATIONS	68,400.00	1,800.00
			TOTAL CHARGES	458,273.00	4,712.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 17:58:09  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 11/01/11 THROUGH 10/31/12  
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: 09/24/2013  
Run Time: 17:58:10  
Page: 4

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 11/01/11 THROUGH 10/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,613,410.62	ADJUSTMENTS	69,234.98
COVERED CHARGES	1,423,254.12	CONTRACTUAL ALLOW	996,587.50
NON-COVERD CHARGES	190,156.50	TOTAL MEDICAID LIAB	426,666.62
		LESS: COB	717.66
		LESS: COPAYMENT	1,536.00
		REIMBURSEMENT	424,412.96
		ALL OTHER	345,705.74
		FEE SCHEDULE-LAB	75,807.74
		INJECTABLE DRUGS	2,899.48

TOTAL NUMBER OF CLAIMS 2,035

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 17:58:10  
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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 11/01/11 THROUGH 10/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,016.52	3,550.00	OTHER LAB	28,863.00	3,628.00
MED/SURG SUPPLY	49,029.00	42.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	100,745.00	707.00	OTHER THERAPEUTIC SVC	0.00	104.00
CT SCAN	135,435.00	7,754.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,748.00	0.00	FEE SCHEDULE LAB	465,369.60	128,651.50
EKG/ECG	25,787.00	107.00	MRI SERVICES	33,786.00	1,332.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	9,918.00
OPERATING ROOM	84,101.00	8,380.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,203.00	1,298.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	266,203.00	4,841.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,313.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,425.00	18,878.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	40.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	49,474.00	150.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,416.00	364.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,360.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,814.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,166.00	412.00			
			TOTAL ANCILLARY	1,423,254.12	190,156.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,423,254.12	190,156.50

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: 09/24/2013  
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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 11/01/11 THROUGH 10/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,687.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,699.00	CONTRACTUAL ALLOW	-1,317.57
NON-COVERD CHARGES	2,988.00	TOTAL MEDICAID LIAB	6,016.57
		LESS: COB	6,007.57
		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

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 11/01/11 THROUGH 10/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386.00	110.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	646.00	135.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,336.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,417.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,053.00	650.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36.00	676.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	934.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	132.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	176.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,699.00	2,988.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,699.00	2,988.00

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: 09/24/2013  
Run Time: 17:58:41  
Page: 8

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 11/01/11 THROUGH 10/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,000.00	ADJUSTMENTS	980.14
COVERED CHARGES	106,351.00	CONTRACTUAL ALLOW	91,226.41
NON-COVERD CHARGES	3,649.00	TOTAL MEDICAID LIAB	15,124.59
		LESS: COB	45.20
		LESS: COPAYMENT	654.02
		REIMBURSEMENT	14,425.37
		TOTAL NUMBER OF CLAIMS	338

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 11/01/11 THROUGH 10/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,262.00	281.00	OTHER LAB	591.00	0.00
MED/SURG SUPPLY	1,868.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,091.00	0.00	OTHER THERAPEUTIC SVC	0.00	26.00
CT SCAN	6,169.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,750.00	2,397.00
EKG/ECG	642.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	545.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,254.00	266.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,827.00	679.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	352.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	106,351.00	3,649.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,351.00	3,649.00

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: 09/24/2013  
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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 11/01/11 THROUGH 10/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	899.00	ADJUSTMENTS	0.00
COVERED CHARGES	740.00	CONTRACTUAL ALLOW	88.00
NON-COVERD CHARGES	159.00	TOTAL MEDICAID LIAB	652.00
		LESS: COB	649.00
		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: 09/24/2013  
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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 11/01/11 THROUGH 10/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	205.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	513.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	159.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	740.00	159.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	740.00	159.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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	11/01/11	THROUGH	10/31/12
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: 09/24/2013  
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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	11/01/11	THROUGH	10/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 17:58:53  
 Page: 1

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	923,798.82	ADJUSTMENTS	17,058.17
COVERED CHARGES	912,190.25	CONTRACTUAL ALLOW	556,562.97
NON-COVERD CHARGES	11,608.57	TOTAL MEDICAID LIAB	355,627.28
		LESS: COB	4,675.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	350,951.43

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	207		0	125,442.00		4,950.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	207		0	125,442.00		4,950.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	25		0	47,400.00		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	25		0	47,400.00		0.00
TOTAL ACCOMODATIONS	232		0	172,842.00		4,950.00

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,386.44	0.00	OTHER LAB	9,947.59	0.00
MED/SURG SUPPLY	29,337.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	206,081.93	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,197.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	87,927.15	1,909.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,956.18	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,071.59	0.00	MRI SERVICES	10,441.14	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,598.05	4,749.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,450.01	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,218.44	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,869.63	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,648.48	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,133.17	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,005.25	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	174.55	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	150.00	0.00	IMPL DEV CHARGE PATIENTS	17,557.77	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,553.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,388.40	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,414.18	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,518.81	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,320.96	0.00			
			TOTAL ANCILLARY	739,348.25	6,658.57
			TOTAL ACCOMODATIONS	172,842.00	4,950.00
			TOTAL CHARGES	912,190.25	11,608.57

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,917.34	ADJUSTMENTS	0.00
COVERED CHARGES	3,917.34	CONTRACTUAL ALLOW	1,862.90
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,054.44
		LESS: COB	2,054.44
		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	606.00		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	606.00		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	606.00		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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,047.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,235.91	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	3,311.34	0.00
			TOTAL ACCOMODATIONS	606.00	0.00
			TOTAL CHARGES	3,917.34	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: 09/24/2013  
Run Time: 17:58:55  
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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,995,071.79	ADJUSTMENTS	103,216.99
COVERED CHARGES	1,783,210.45	CONTRACTUAL ALLOW	1,408,877.81
NON-COVERD CHARGES	211,861.34	TOTAL MEDICAID LIAB	374,332.64
		LESS: COB	1,029.52
		LESS: COPAYMENT	1,617.00
		REIMBURSEMENT	371,686.12
		ALL OTHER	320,452.95
		FEE SCHEDULE-LAB	43,149.79
		INJECTABLE DRUGS	8,083.38
		TOTAL NUMBER OF CLAIMS	1,387



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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,327.72	104.75	OTHER LAB	45,928.54	0.00
MED/SURG SUPPLY	33,295.95	213.58	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	135,657.72	1,888.07	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	336,318.75	48,439.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	384,627.92	98,552.33
EKG/ECG	29,440.41	1,959.57	MRI SERVICES	57,045.79	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	163,391.61	34,538.16	DURABLE MED. EQUIP.	0.00	24.93
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,355.05	3,273.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,464.74	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	361,268.07	5,761.48	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,709.26	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,034.90	11,049.44
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	140.36	378.30	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	150.00	0.00	IMPL DEV CHARGE PATIENTS	2,128.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54,187.32	1,061.71			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,546.17	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,439.16	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,752.94	4,616.23			
			TOTAL ANCILLARY	1,783,210.45	211,861.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,783,210.45	211,861.34

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 17:59:10  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,292.41	ADJUSTMENTS	0.00
COVERED CHARGES	62,419.73	CONTRACTUAL ALLOW	23,451.74
NON-COVERD CHARGES	5,872.68	TOTAL MEDICAID LIAB	38,967.99
		LESS: COB	38,880.99
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 62

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	249.04	79.12	OTHER LAB	1,783.47	0.00
MED/SURG SUPPLY	351.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,657.26	573.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,932.06	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,503.14	3,282.36
EKG/ECG	3,063.84	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,718.98	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	103.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,141.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	366.42	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	476.98	259.38
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	2,071.36	1,678.17			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	62,419.73	5,872.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	62,419.73	5,872.68

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: 09/24/2013  
Run Time: 17:59:11  
Page: 9

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,497.38	ADJUSTMENTS	549.18
COVERED CHARGES	112,407.93	CONTRACTUAL ALLOW	101,779.35
NON-COVERD CHARGES	4,089.45	TOTAL MEDICAID LIAB	10,628.58
		LESS: COB	40.00
		LESS: COPAYMENT	381.18
		REIMBURSEMENT	10,207.40
		TOTAL NUMBER OF CLAIMS	190

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,127.09	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	465.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,545.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,774.07	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,020.73	2,897.03
EKG/ECG	653.19	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	226.08	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	73,995.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,685.78	284.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	925.60	588.38			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,988.40	320.04			
			TOTAL ANCILLARY	112,407.93	4,089.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	112,407.93	4,089.45



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 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	908.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	161.52	0.00
EKG/ECG	217.73	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,365.38	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	96.43	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,749.98	6.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,749.98	6.00

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

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER 000001482A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,421,910.54	ADJUSTMENTS	3,426,465.36
COVERED CHARGES	74,275,448.76	CONTRACTUAL ALLOW	51,165,894.09
NON-COVERD CHARGES	3,146,461.78	TOTAL MEDICAID LIAB	23,109,554.67
		LESS: COB	107,608.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,001,946.43

TOTAL NUMBER OF ADMISSIONS 2,595

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,967		0	5,723,620.00		1,270,286.00
ROUTINE NURSERY	1,240		0	538,800.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,207		0	6,262,420.00		1,270,286.00
SPECIAL CARE SERVICES						
CCU	508		0	670,293.50		0.00
ICU	1,727		1	1,770,496.00		1,320.00
NICU	1,082		0	1,473,748.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		138	0.00		77,805.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,317		139	3,914,537.50		79,125.00
TOTAL ACCOMODATIONS	16,524		139	10,176,957.50		1,349,411.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,335,424.19	10,271.30	OTHER LAB	342,976.00	609.00
MED/SURG SUPPLY	6,221,253.07	93,658.74	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,813,575.11	22,143.00	EDUCATION & TRAINING	1,296.00	0.00
RADIOLOGY-DIAGNOSTIC	1,378,371.00	4,637.00	OTHER THERAPEUTIC SVC	0.00	25,055.00
CT SCAN	1,254,696.00	819,874.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	557,609.00	9,528.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	321,754.43	0.00	MRI SERVICES	713,071.00	0.00
IV THERAPY	147,194.00	1,340.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,937,903.50	24,410.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	202,642.00	0.00	REHAB THERAPY	12,352.00	0.00
RESPIRATORY SERVICES	2,322,287.00	1,440.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	471,984.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	334,234.00	3,818.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,083,081.00	6,922.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	746,233.91	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	214,434.00	0.00	INJECTABLE DRUGS	3,740,864.43	30,588.70
RADIOLOGY THERAPEUTIC	770,241.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	304,755.00	5,369.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	84,785.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	280,988.00	39,004.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120.00	53,075.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,665.00	0.00	IMPL DEV CHARGE PATIENTS	3,474,026.77	0.00
LITHOTRIPSY	16,718.00	0.00	NO CC/INVALID REV CODE	0.00	20,544.04
OTHER IMAGING SERVICE	332,634.00	8,500.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,689,592.00	586,638.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	247,358.00	0.00			
AUDIOLOGY	45,003.00	0.00			
CARDIOLOGY	2,182,257.00	2,385.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,352.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,455,760.10	27,241.00			
			TOTAL ANCILLARY	64,098,491.26	1,797,050.78
			TOTAL ACCOMODATIONS	10,176,957.50	1,349,411.00
			TOTAL CHARGES	74,275,448.76	3,146,461.78

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
36	2212009012079	12/09/11 - 12/20/11	01/16/12	0.00	646.00	0.00	0.00	0.00
615	2012193067688	12/09/11 - 12/13/11	07/16/12	0.00	2,171.00	0.00	0.00	0.00
615	2012205009163	07/12/12 - 07/16/12	07/30/12	0.00	2,171.00	0.00	0.00	0.00
2710	2212215010051	05/27/12 - 06/05/12	08/06/12	0.00	259.04	0.00	0.00	0.00
615	2212216007872	04/09/12 - 05/12/12	08/06/12	0.00	2,171.00	0.00	0.00	0.00
615	2012219015842	03/17/12 - 03/22/12	08/13/12	0.00	2,171.00	0.00	0.00	0.00
3710	2212264007207	05/26/12 - 05/30/12	09/24/12	0.00	100.00	0.00	0.00	0.00
615	5912269002404	05/21/12 - 05/29/12	10/01/12	0.00	2,171.00	0.00	0.00	0.00
615	5912304001036	05/05/12 - 05/18/12	11/05/12	0.00	2,171.00	0.00	0.00	0.00
615	2212314016939	04/24/12 - 05/24/12	11/12/12	0.00	2,171.00	0.00	0.00	0.00
615	2013200071502	07/27/12 - 08/01/12	07/29/13	0.00	2,171.00	0.00	0.00	0.00
615	2013212066046	12/02/11 - 12/21/11	08/05/13	0.00	2,171.00	0.00	0.00	0.00
TOTAL				0.00	20,544.04	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	379,113.89	ADJUSTMENTS	0.00
COVERED CHARGES	365,848.89	CONTRACTUAL ALLOW	85,490.48
NON-COVERD CHARGES	13,265.00	TOTAL MEDICAID LIAB	280,358.41
		LESS: COB	280,358.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	45		0	21,460.00		60.00
ROUTINE NURSERY	0		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	21,460.00		60.00
SPECIAL CARE SERVICES						
CCU	7		0	9,240.00		0.00
ICU	10		0	13,200.00		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	17		0	22,440.00		0.00
TOTAL ACCOMODATIONS	62		0	43,900.00		60.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,776.86	0.00	OTHER LAB	2,701.00	0.00
MED/SURG SUPPLY	29,400.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	42,772.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,237.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,978.00	9,240.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,842.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,046.00	0.00	MRI SERVICES	9,044.00	0.00
IV THERAPY	2,331.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,170.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,764.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,930.00	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	9,011.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,267.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,299.00	0.00	INJECTABLE DRUGS	16,401.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,412.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	13,532.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,210.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,171.00
OTHER IMAGING SERVICE	3,385.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,246.00	1,794.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,387.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,210.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,135.50	0.00			
			TOTAL ANCILLARY	321,948.89	13,205.00
			TOTAL ACCOMODATIONS	43,900.00	60.00
			TOTAL CHARGES	365,848.89	13,265.00

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 PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1112193004392	04/03/12 - 04/07/12	07/23/12	0.00	2,171.00	0.00	27,169.99	0.00
TOTAL				0.00	2,171.00	0.00	27,169.99	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,408,911.26	ADJUSTMENTS	1,431,002.15
COVERED CHARGES	35,718,059.86	CONTRACTUAL ALLOW	27,403,981.28
NON-COVERD CHARGES	2,690,851.40	TOTAL MEDICAID LIAB	8,314,078.58
		LESS: COB	1,210.88
		LESS: COPAYMENT	38,254.91
		REIMBURSEMENT	8,274,612.79
		ALL OTHER	6,868,828.70
		FEE SCHEDULE-LAB	563,261.44
		INJECTABLE DRUGS	842,522.65
		TOTAL NUMBER OF CLAIMS	18,647



PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,781,852.41	16,317.23	OTHER LAB	191,568.00	1,964.00
MED/SURG SUPPLY	2,299,953.39	6,703.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	479.00	EDUCATION & TRAINING	1,372.00	324.00
RADIOLOGY-DIAGNOSTIC	994,449.00	31,026.00	OTHER THERAPEUTIC SVC	1,290.00	3,876.00
CT SCAN	2,114,146.00	108,376.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	58,520.00	23,442.00	FEE SCHEDULE LAB	3,074,872.53	521,251.17
EKG/ECG	248,867.00	20,088.00	MRI SERVICES	615,899.00	36,377.00
IV THERAPY	1,024,597.00	40,914.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,161,494.00	261,626.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	97,702.00	0.00	REHAB THERAPY	2,720.00	0.00
RESPIRATORY SERVICES	262,961.00	32,463.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	303,018.00	207.00	AMBULANCE	0.00	0.00
GI SERVICES	676,990.00	37,020.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,754,792.00	71,924.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	684,330.70	2,360.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,304,444.35	783,326.95
RADIOLOGY THERAPEUTIC	3,651,793.00	32,872.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,309.00	7,206.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,889.00	8,703.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,000.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,027,068.00	272,690.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	480,075.00	0.00	IMPL DEV CHARGE PATIENTS	320,802.00	83,354.00
LITHOTRIPSY	138,506.00	0.00	NO CC/INVALID REV CODE	0.00	440.00
OTHER IMAGING SERVICE	869,482.00	47,865.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	172,623.00	45,063.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	820,271.00	2,919.00			
AUDIOLOGY	9,023.00	4,277.00			
CARDIOLOGY	697,419.00	155,945.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	426,740.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	424,221.48	28,452.25			
			TOTAL ANCILLARY	35,718,059.86	2,690,851.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,718,059.86	2,690,851.40

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	2212058005525	01/03/12 - 01/03/12	03/05/12	0.00	70.00	0.00	0.00	0.00
9921	5912150000014	11/14/11 - 11/14/11	06/04/12	0.00	137.00	0.00	0.00	0.00
76	2212196000509	01/14/12 - 01/14/12	07/23/12	0.00	76.00	0.00	0.00	0.00
26	5912206002273	03/18/12 - 03/19/12	07/30/12	0.00	102.00	0.00	0.00	0.00
807	5913085000356	10/28/11 - 10/28/11	04/01/13	0.00	55.00	0.00	0.00	0.00
TOTAL				0.00	440.00	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

PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	471,322.81	ADJUSTMENTS	0.00
COVERED CHARGES	431,933.15	CONTRACTUAL ALLOW	222,364.16
NON-COVERD CHARGES	39,389.66	TOTAL MEDICAID LIAB	209,568.99
		LESS: COB	209,163.56
		LESS: COPAYMENT	405.43
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 163

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,935.00	859.71	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33,968.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	198.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,569.00	587.00	OTHER THERAPEUTIC SVC	645.00	0.00
CT SCAN	13,630.00	1,403.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,636.00	701.00	FEE SCHEDULE LAB	33,555.00	4,585.00
EKG/ECG	3,482.00	0.00	MRI SERVICES	7,281.00	0.00
IV THERAPY	9,178.00	984.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,706.00	18,645.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,112.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	756.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,860.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,260.00	3,120.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,651.00	762.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,190.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	115,361.49	890.95
RADIOLOGY THERAPEUTIC	37,706.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,925.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,592.00	1,221.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,401.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,983.00	2,065.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,091.00	1,443.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,078.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	658.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,648.66	0.00			
			TOTAL ANCILLARY	431,933.15	39,389.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	431,933.15	39,389.66

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,126,410.20	ADJUSTMENTS	2,135.59
COVERED CHARGES	1,092,172.10	CONTRACTUAL ALLOW	1,036,232.10
NON-COVERD CHARGES	34,238.10	TOTAL MEDICAID LIAB	55,940.00
		LESS: COB	0.00
		LESS: COPAYMENT	2,142.09
		REIMBURSEMENT	53,797.91
		TOTAL NUMBER OF CLAIMS	1,000

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,930.31	0.00	OTHER LAB	4,564.00	0.00
MED/SURG SUPPLY	32,160.47	89.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	108.00	0.00
RADIOLOGY-DIAGNOSTIC	68,799.00	1,124.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,841.00	4,209.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	122,146.00	17,866.00
EKG/ECG	10,044.00	0.00	MRI SERVICES	7,892.00	3,943.00
IV THERAPY	14,404.00	660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,603.00	1.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,184.00	850.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	460.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	613,451.00	2,388.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	990.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,624.47	1,681.10
RADIOLOGY THERAPEUTIC	19,178.00	555.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	353.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	237.00	332.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,113.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,057.00	187.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,774.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,611.85	0.00			
			TOTAL ANCILLARY	1,092,172.10	34,238.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,092,172.10	34,238.10

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,048.05	ADJUSTMENTS	0.00
COVERED CHARGES	9,838.05	CONTRACTUAL ALLOW	5,107.86
NON-COVERD CHARGES	210.00	TOTAL MEDICAID LIAB	4,730.19
		LESS: COB	4,709.19
		LESS: COPAYMENT	21.00
		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

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	493.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	99.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,222.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,516.00	40.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	84.00	170.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,144.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	280.05	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	9,838.05	210.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,838.05	210.00



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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,186,271.13	ADJUSTMENTS	485,730.19
COVERED CHARGES	7,829,090.38	CONTRACTUAL ALLOW	6,767,193.71
NON-COVERD CHARGES	357,180.75	TOTAL MEDICAID LIAB	1,061,896.67
		LESS: COB	0.00
		LESS: COPAYMENT	1,683.00
		REIMBURSEMENT	1,060,213.67
		TOTAL NUMBER OF CLAIMS	196

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	283,326.42	297.40	OTHER LAB	10,356.00	0.00
MED/SURG SUPPLY	362,346.60	264.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	60.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,807.00	18,315.00	OTHER THERAPEUTIC SVC	0.00	165.00
CT SCAN	30,860.00	3,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,277.00	1,381.00	FEE SCHEDULE LAB	66,552.50	19,681.50
EKG/ECG	11,104.00	2,604.00	MRI SERVICES	8,053.00	0.00
IV THERAPY	233,288.00	3,564.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	503,166.00	89,553.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	170.00	0.00
RESPIRATORY SERVICES	20,800.00	84.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,393.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,392.00	2,581.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	60,978.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,601,120.96	57,562.85
RADIOLOGY THERAPEUTIC	605,431.00	6,498.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,614.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,965.00	9,052.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	910,555.00	57,512.00
LITHOTRIPSY	131,312.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,444.00	1,164.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	48,091.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,618.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	743,619.00	81,606.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,770.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	63,294.05	140.00			
			TOTAL ANCILLARY	7,829,090.38	357,180.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,829,090.38	357,180.75

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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Page: 18

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,615.00	ADJUSTMENTS	0.00
COVERED CHARGES	88,615.00	CONTRACTUAL ALLOW	31,223.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	57,391.51
		LESS: COB	57,376.51
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,429.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,605.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	535.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,901.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75,573.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	572.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	88,615.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	88,615.00	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: 09/24/2013  
 Run Time: 18:05:03  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
 1266 HIGHWAY 515 S  
 JASPER,GA 30143-4872

PROVIDER NUMBER  
 000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,378,329.31	ADJUSTMENTS	109,297.26
COVERED CHARGES	5,321,248.71	CONTRACTUAL ALLOW	3,651,356.18
NON-COVERD CHARGES	57,080.60	TOTAL MEDICAID LIAB	1,669,892.53
		LESS: COB	3,606.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,666,286.07

TOTAL NUMBER OF ADMISSIONS 234

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	644		0	553,840.00		28,980.00
ROUTINE NURSERY	49		0	30,135.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	693		0	583,975.00		28,980.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	190		0	424,975.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	190		0	424,975.00		0.00
TOTAL ACCOMODATIONS	883		0	1,008,950.00		28,980.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
 1266 HIGHWAY 515 S  
 JASPER,GA 30143-4872

PROVIDER NUMBER  
 000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,063,837.03	5,887.60	OTHER LAB	36,708.00	0.00
MED/SURG SUPPLY	75,564.50	75.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	847,877.19	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125,862.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	281,956.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,294.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	50,434.00	0.00	MRI SERVICES	43,489.00	0.00
IV THERAPY	36,803.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	311,369.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	111,672.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	371,184.00	475.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,139.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	32,049.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	298,441.00	1,080.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	83,008.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	162.00	0.00	INJECTABLE DRUGS	2,692.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,056.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,760.00	321.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,386.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	58,146.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	106,841.00	17,822.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,134.00	2,440.00			
AUDIOLOGY	5,264.00	0.00			
CARDIOLOGY	152,570.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50,600.04	0.00			
			TOTAL ANCILLARY	4,312,298.71	28,100.60
			TOTAL ACCOMODATIONS	1,008,950.00	28,980.00
			TOTAL CHARGES	5,321,248.71	57,080.60

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 09/24/2013  
 Run Time: 18:05:09  
 Page: 3

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,670.30	ADJUSTMENTS	0.00
COVERED CHARGES	58,355.30	CONTRACTUAL ALLOW	45,929.75
NON-COVERD CHARGES	315.00	TOTAL MEDICAID LIAB	12,425.55
		LESS: COB	12,425.55
		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	6,020.00		315.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	6,020.00		315.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	7		0	6,020.00		315.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
 1266 HIGHWAY 515 S  
 JASPER,GA 30143-4872

PROVIDER NUMBER  
 000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,979.05	0.00	OTHER LAB	770.00	0.00
MED/SURG SUPPLY	784.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,182.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,580.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,940.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,736.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,138.00	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	4,227.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	420.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,419.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,160.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	52,335.30	0.00
			TOTAL ACCOMODATIONS	6,020.00	315.00
			TOTAL CHARGES	58,355.30	315.00



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: 09/24/2013  
Run Time: 18:05:10  
Page: 5

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,440,544.40	ADJUSTMENTS	230,596.68
COVERED CHARGES	7,590,681.39	CONTRACTUAL ALLOW	6,084,688.85
NON-COVERD CHARGES	849,863.01	TOTAL MEDICAID LIAB	1,505,992.54
		LESS: COB	4,690.87
		LESS: COPAYMENT	3,105.00
		REIMBURSEMENT	1,498,196.67
		ALL OTHER	1,373,456.91
		FEE SCHEDULE-LAB	99,924.50
		INJECTABLE DRUGS	24,815.26

TOTAL NUMBER OF CLAIMS 3,146

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,421.05	3,834.95	OTHER LAB	76,485.00	0.00
MED/SURG SUPPLY	154,547.12	7,708.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	225.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	375,738.00	12,157.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,348,450.00	78,957.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	675.00	FEE SCHEDULE LAB	1,306,410.65	214,066.70
EKG/ECG	106,212.00	1,002.00	MRI SERVICES	470,484.00	72,760.00
IV THERAPY	41,150.00	2,994.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	726,304.00	205,163.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	63,048.00	368.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,925.00	5,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,009.00	1,948.00	AMBULANCE	0.00	0.00
GI SERVICES	104,313.00	29,445.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,116,459.00	33,338.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	224,352.00	1,824.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	101,771.90	56,856.90
RADIOLOGY THERAPEUTIC	2,390.00	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	575.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30,875.00	2,492.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,176.62	46,128.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	153,634.00	12,487.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,930.50	11,730.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	186,775.00	23,941.00			
AUDIOLOGY	188.00	0.00			
CARDIOLOGY	275,943.00	7,803.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	152,747.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	126,942.55	16,310.86			
			TOTAL ANCILLARY	7,590,681.39	849,863.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,590,681.39	849,863.01

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	148,813.60	ADJUSTMENTS	0.00
COVERED CHARGES	107,627.60	CONTRACTUAL ALLOW	70,481.67
NON-COVERD CHARGES	41,186.00	TOTAL MEDICAID LIAB	37,145.93
		LESS: COB	37,082.93
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 53

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,170.60	0.00	OTHER LAB	423.00	0.00
MED/SURG SUPPLY	285.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	48.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,915.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,492.00	11,055.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	45,581.00	13,071.00
EKG/ECG	1,002.00	0.00	MRI SERVICES	6,426.00	8,529.00
IV THERAPY	239.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,009.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,016.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	728.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,385.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,624.00	461.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	112.00	828.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	339.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,662.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,115.00	1,621.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,969.00	526.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,470.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	843.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	869.00	0.00			
			TOTAL ANCILLARY	107,627.60	41,186.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,627.60	41,186.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	557,043.95	ADJUSTMENTS	1,023.83
COVERED CHARGES	526,960.15	CONTRACTUAL ALLOW	503,633.17
NON-COVERD CHARGES	30,083.80	TOTAL MEDICAID LIAB	23,326.98
		LESS: COB	0.00
		LESS: COPAYMENT	819.05
		REIMBURSEMENT	22,507.93
		TOTAL NUMBER OF CLAIMS	417

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,236.05	0.00	OTHER LAB	748.00	0.00
MED/SURG SUPPLY	1,602.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,395.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,185.00	2,112.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	95,720.00	7,830.00
EKG/ECG	6,346.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	12,561.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,956.00	97.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,490.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	274,334.00	3,418.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,824.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,484.00	217.80
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	8,640.00	3,848.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	526,960.15	30,083.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	526,960.15	30,083.80



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	250.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	468.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,441.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,097.00	314.00
EKG/ECG	668.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	8,145.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	659.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,257.00	973.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,257.00	973.00



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: 09/24/2013  
Run Time: 18:05:44  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	519,597.18	ADJUSTMENTS	35,802.26
COVERED CHARGES	493,777.18	CONTRACTUAL ALLOW	401,897.94
NON-COVERD CHARGES	25,820.00	TOTAL MEDICAID LIAB	91,879.24
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	91,756.24

TOTAL NUMBER OF CLAIMS 18

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,941.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	83,738.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,062.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,141.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,342.00	694.00
EKG/ECG	2,672.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	790.00	1,795.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	220,874.00	14,514.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	806.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,741.00	2,430.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,164.00	222.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,536.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,798.20	996.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,879.05	4,947.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,500.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,667.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,124.33	222.00			
			TOTAL ANCILLARY	493,777.18	25,820.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	493,777.18	25,820.00

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: 09/24/2013  
Run Time: 18:05:45  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER 000001504A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,446,203.45	ADJUSTMENTS	4,240,508.07
COVERED CHARGES	50,414,434.40	CONTRACTUAL ALLOW	37,240,322.57
NON-COVERD CHARGES	1,031,769.05	TOTAL MEDICAID LIAB	13,174,111.83
		LESS: COB	202,849.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,971,262.67

TOTAL NUMBER OF ADMISSIONS 719

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,272		5	3,719,045.00		279,647.00
ROUTINE NURSERY	258		0	350,145.00		11,205.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,530		5	4,069,190.00		290,852.00
SPECIAL CARE SERVICES						
CCU	229		0	555,325.00		0.00
ICU	1,033		0	2,618,085.00		0.00
NICU	14		0	34,020.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,276		0	3,207,430.00		0.00
TOTAL ACCOMODATIONS	5,806		5	7,276,620.00		290,852.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,033,381.39	61,271.97	OTHER LAB	342,568.00	0.00
MED/SURG SUPPLY	1,884,674.21	397,875.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,551,410.00	45,281.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,423,254.00	757.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,688,988.00	21,475.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	284,164.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	213,450.00	526.00	MRI SERVICES	639,215.00	0.00
IV THERAPY	265.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,097,160.00	6,125.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	94,902.00	2,368.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,819,051.00	1,252.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	621,613.00	5,824.00	AMBULANCE	0.00	0.00
GI SERVICES	362,714.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	808,695.40	11,962.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	447,390.00	4,453.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	226,770.00	0.00	INJECTABLE DRUGS	96,029.50	59.00
RADIOLOGY THERAPEUTIC	117,151.00	7,098.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	115,383.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	83,443.00	432.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	838,619.00	28,154.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,048.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,057,619.12	862.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	211,099.02	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,188,064.00	57,139.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	220,650.00	28,392.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,043,768.00	3,578.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	59,008.00	0.00			
ORGAN ACQUISITION	472,315.00	51,311.00			
TREATMENT/OBSERV. RM	95,000.76	674.08			
			TOTAL ANCILLARY	43,137,814.40	740,917.05
			TOTAL ACCOMODATIONS	7,276,620.00	290,852.00
			TOTAL CHARGES	50,414,434.40	1,031,769.05

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,348,957.30	ADJUSTMENTS	0.00
COVERED CHARGES	2,293,788.30	CONTRACTUAL ALLOW	1,281,474.57
NON-COVERD CHARGES	55,169.00	TOTAL MEDICAID LIAB	1,012,313.73
		LESS: COB	1,012,313.73
		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	87		0	76,125.00		5,655.00
ROUTINE NURSERY	96		0	157,645.00		5,810.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	183		0	233,770.00		11,465.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	73		0	177,025.00		0.00
NICU	79		0	191,970.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	152		0	368,995.00		0.00
TOTAL ACCOMODATIONS	335		0	602,765.00		11,465.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	522,608.05	0.00	OTHER LAB	14,671.00	0.00
MED/SURG SUPPLY	77,647.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	295,608.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	72,591.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,557.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,386.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,471.00	0.00	MRI SERVICES	13,613.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,420.00	40,349.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	24,034.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	232,503.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,957.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,008.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,312.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,804.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,963.00	0.00	INJECTABLE DRUGS	16,481.50	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	432.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	34,187.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,407.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,470.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,798.00	3,057.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,436.00	298.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,660.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	655.00	0.00			
ORGAN ACQUISITION	94,463.00	0.00			
TREATMENT/OBSERV. RM	1,880.00	0.00			
			TOTAL ANCILLARY	1,691,023.30	43,704.00
			TOTAL ACCOMODATIONS	602,765.00	11,465.00
			TOTAL CHARGES	2,293,788.30	55,169.00

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: 09/24/2013  
Run Time: 18:06:09  
Page: 5

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,070,035.42	ADJUSTMENTS	361,536.35
COVERED CHARGES	10,142,532.49	CONTRACTUAL ALLOW	8,154,759.76
NON-COVERD CHARGES	2,927,502.93	TOTAL MEDICAID LIAB	1,987,772.73
		LESS: COB	24,357.15
		LESS: COPAYMENT	4,736.73
		REIMBURSEMENT	1,958,678.85
		ALL OTHER	1,686,504.60
		FEE SCHEDULE-LAB	176,161.57
		INJECTABLE DRUGS	96,012.68

TOTAL NUMBER OF CLAIMS 3,415



PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	396,004.24	4,667.00	OTHER LAB	104,119.00	0.00
MED/SURG SUPPLY	438,934.55	991.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	516.00	0.00
RADIOLOGY-DIAGNOSTIC	531,243.00	22,052.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,035,887.00	187,087.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,053.00	29,674.00	FEE SCHEDULE LAB	2,030,319.50	486,058.80
EKG/ECG	131,223.00	1,315.00	MRI SERVICES	440,873.00	28,920.00
IV THERAPY	49,238.00	7,764.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	823,331.00	93,933.00	DURABLE MED. EQUIP.	0.00	148.00
LABOR/DELIVERY ROOM	10,580.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	62,322.00	4,778.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	98,712.00	2,840.00	AMBULANCE	0.00	0.00
GI SERVICES	183,328.00	61,328.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,114,723.00	67,538.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	203,367.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	433,618.14	242,905.20
RADIOLOGY THERAPEUTIC	112,383.00	23,667.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	357.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	554.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	22,121.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	140,059.00	21,743.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,501.00	1,170,409.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	360,363.00	52,921.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,037.00	1,358.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	310,931.00	90,350.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	819,634.00	297,489.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,961.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	229,272.06	4,534.68			
			TOTAL ANCILLARY	10,142,532.49	2,927,502.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,142,532.49	2,927,502.93

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: 09/24/2013  
Run Time: 18:06:42  
Page: 7

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	426,372.47	ADJUSTMENTS	0.00
COVERED CHARGES	272,434.87	CONTRACTUAL ALLOW	157,350.43
NON-COVERD CHARGES	153,937.60	TOTAL MEDICAID LIAB	115,084.44
		LESS: COB	114,891.08
		LESS: COPAYMENT	193.36
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 101

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,299.60	88.00	OTHER LAB	3,872.00	0.00
MED/SURG SUPPLY	13,855.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	26.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,069.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,609.00	30,596.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,853.00	30,919.00
EKG/ECG	3,156.00	0.00	MRI SERVICES	0.00	24,203.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,448.00	33,390.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,652.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,183.00	101.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,308.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,941.00	2,353.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,124.00	1,709.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,213.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56.00	8,793.60
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	182.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,882.00	300.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,154.00	4,657.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,492.00	16,620.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,591.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,677.27	0.00			
			TOTAL ANCILLARY	272,434.87	153,937.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	272,434.87	153,937.60

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: 09/24/2013  
Run Time: 18:06:46  
Page: 9

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	303,081.85	ADJUSTMENTS	105.88
COVERED CHARGES	291,063.95	CONTRACTUAL ALLOW	279,036.85
NON-COVERD CHARGES	12,017.90	TOTAL MEDICAID LIAB	12,027.10
		LESS: COB	0.00
		LESS: COPAYMENT	549.00
		REIMBURSEMENT	11,478.10
		TOTAL NUMBER OF CLAIMS	215

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,823.70	629.30	OTHER LAB	2,822.00	0.00
MED/SURG SUPPLY	183.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,681.00	292.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,775.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	59,681.00	6,812.00
EKG/ECG	6,049.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	265.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	129,554.00	2,070.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,107.00	1,614.60
RADIOLOGY THERAPEUTIC	1,270.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	657.00	600.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,994.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	291,063.95	12,017.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	291,063.95	12,017.90

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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Page: 11

SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,077.60	ADJUSTMENTS	0.00
COVERED CHARGES	16,283.60	CONTRACTUAL ALLOW	8,189.20
NON-COVERD CHARGES	794.00	TOTAL MEDICAID LIAB	8,094.40
		LESS: COB	8,070.40
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	744.60	0.00	OTHER LAB	789.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,866.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,654.00	104.00
EKG/ECG	526.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,575.00	690.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,283.60	794.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,283.60	794.00

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 HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,457,447.45	ADJUSTMENTS	135,487.32
COVERED CHARGES	2,830,464.35	CONTRACTUAL ALLOW	2,394,772.63
NON-COVERD CHARGES	626,983.10	TOTAL MEDICAID LIAB	435,691.72
		LESS: COB	6,751.13
		LESS: COPAYMENT	873.00
		REIMBURSEMENT	428,067.59

TOTAL NUMBER OF CLAIMS 77



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,334.06	2,360.00	OTHER LAB	2,725.00	0.00
MED/SURG SUPPLY	277,003.50	110.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	87,684.00	25,744.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	75,375.00	1,555.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,234.00	FEE SCHEDULE LAB	61,249.20	17,833.20
EKG/ECG	14,465.00	789.00	MRI SERVICES	14,305.00	4,956.00
IV THERAPY	28,218.00	265.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	212,873.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,595.00	303.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,911.00	1,988.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,978.00	1,410.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,809.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	635,286.29	73,753.90
RADIOLOGY THERAPEUTIC	556,062.00	6,613.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	619.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	955.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	99,559.00	376,169.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,850.00	928.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,255.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,939.00	1,158.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	508,233.00	107,658.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	89,800.30	1,537.00			
			TOTAL ANCILLARY	2,830,464.35	626,983.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,830,464.35	626,983.10

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 HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,058.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,558.00	CONTRACTUAL ALLOW	12,071.24
NON-COVERD CHARGES	1,500.00	TOTAL MEDICAID LIAB	27,486.76
		LESS: COB	27,483.76
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,137.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,250.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	899.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,190.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,869.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,692.00	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	2,421.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.00	1,500.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	39,558.00	1,500.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,558.00	1,500.00

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: 09/24/2013  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	06/30/12
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: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 18:07:39  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,037.00	ADJUSTMENTS	0.00
COVERED CHARGES	33,914.00	CONTRACTUAL ALLOW	27,467.25
NON-COVERD CHARGES	10,123.00	TOTAL MEDICAID LIAB	6,446.75
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	6,443.75
		ALL OTHER	4,881.78
		FEE SCHEDULE-LAB	1,503.18
		INJECTABLE DRUGS	58.79

TOTAL NUMBER OF CLAIMS 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

Run Date: 09/24/2013  
 Run Time: 18:07:39  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,500.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,014.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	980.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,951.00	8,944.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,455.00	1,179.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,819.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,145.50	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	49.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,914.00	10,123.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,914.00	10,123.00

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

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	06/30/12
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: 09/24/2013  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,485.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,485.00	CONTRACTUAL ALLOW	1,385.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	100.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	97.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	163.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,322.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,485.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,485.00	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

Run Date: 09/24/2013  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	06/30/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	06/30/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:07:01  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER 000001526A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,380.08	ADJUSTMENTS	0.00
COVERED CHARGES	42,005.08	CONTRACTUAL ALLOW	21,299.77
NON-COVERD CHARGES	375.00	TOTAL MEDICAID LIAB	20,705.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,705.31

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	3,340.00		375.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	3,340.00		375.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	10		0	3,340.00		375.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:07:01  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,478.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,246.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,361.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,109.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	319.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,702.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,068.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,718.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,361.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	302.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,665.08	0.00
			TOTAL ACCOMODATIONS	3,340.00	375.00
			TOTAL CHARGES	42,005.08	375.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:07:02  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 03/31/12  
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: 09/24/2013  
Run Time: 18:07:02  
Page: 4

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,156,759.69	ADJUSTMENTS	47,191.83
COVERED CHARGES	1,864,782.97	CONTRACTUAL ALLOW	1,563,205.96
NON-COVERD CHARGES	291,976.72	TOTAL MEDICAID LIAB	301,577.01
		LESS: COB	736.58
		LESS: COPAYMENT	1,119.00
		REIMBURSEMENT	299,721.43
		ALL OTHER	263,613.48
		FEE SCHEDULE-LAB	35,004.38
		INJECTABLE DRUGS	1,103.57
		TOTAL NUMBER OF CLAIMS	1,393

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,187.38	64.08	OTHER LAB	4,914.00	691.00
MED/SURG SUPPLY	18,944.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	169,724.00	2,722.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	239,212.00	18,506.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,079.00	3,373.00	FEE SCHEDULE LAB	707,117.00	250,480.40
EKG/ECG	16,269.00	0.00	MRI SERVICES	26,443.00	0.00
IV THERAPY	41,087.00	4,408.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,950.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	548,551.00	471.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,634.59	7,894.24
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	29,985.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,367.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,686.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,864,782.97	291,976.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,864,782.97	291,976.72

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,523.06	ADJUSTMENTS	0.00
COVERED CHARGES	18,496.37	CONTRACTUAL ALLOW	8,688.91
NON-COVERD CHARGES	26.69	TOTAL MEDICAID LIAB	9,807.46
		LESS: COB	9,807.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	965.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	455.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,620.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,086.00	0.00
EKG/ECG	319.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	530.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,243.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277.83	26.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,496.37	26.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,496.37	26.69

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: 09/24/2013  
Run Time: 18:07:27  
Page: 8

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	240,887.46	ADJUSTMENTS	851.99
COVERED CHARGES	230,393.61	CONTRACTUAL ALLOW	217,243.61
NON-COVERD CHARGES	10,493.85	TOTAL MEDICAID LIAB	13,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	483.01
		REIMBURSEMENT	12,666.99
		TOTAL NUMBER OF CLAIMS	263

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,492.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,654.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,220.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,264.00	3,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,993.00	6,078.00
EKG/ECG	1,914.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,189.00	228.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,044.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	148,562.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,061.12	923.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	230,393.61	10,493.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	230,393.61	10,493.85

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: 09/24/2013  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,468.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,468.00	CONTRACTUAL ALLOW	725.05
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	742.95
		LESS: COB	742.95
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,468.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,468.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,468.00	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 FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	03/31/12
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: 09/24/2013  
Run Time: 18:07:32  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	03/31/12
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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	424,809.11	ADJUSTMENTS	23,680.80
COVERED CHARGES	414,498.66	CONTRACTUAL ALLOW	114,588.87
NON-COVERD CHARGES	10,310.45	TOTAL MEDICAID LIAB	299,909.79
		LESS: COB	670.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	299,239.79

TOTAL NUMBER OF ADMISSIONS 62

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	138		0	45,825.00		2,475.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	138		0	45,825.00		2,475.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	19		0	12,825.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	19		0	12,825.00		0.00
TOTAL ACCOMODATIONS	157		0	58,650.00		2,475.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108,646.68	0.00	OTHER LAB	4,724.04	0.00
MED/SURG SUPPLY	43,340.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	65,258.47	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,656.97	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,403.86	7,631.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	601.64	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,664.62	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,297.87	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,348.01	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,153.08	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,578.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	562.39	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,488.97	203.53			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,578.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,545.07	0.00			
			TOTAL ANCILLARY	355,848.66	7,835.45
			TOTAL ACCOMODATIONS	58,650.00	2,475.00
			TOTAL CHARGES	414,498.66	10,310.45

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 18:07:47  
Page: 4

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,040,219.52	ADJUSTMENTS	78,363.10
COVERED CHARGES	947,728.52	CONTRACTUAL ALLOW	499,433.08
NON-COVERD CHARGES	92,491.00	TOTAL MEDICAID LIAB	448,295.44
		LESS: COB	2,025.19
		LESS: COPAYMENT	624.00
		REIMBURSEMENT	445,646.25
		ALL OTHER	411,927.33
		FEE SCHEDULE-LAB	25,380.76
		INJECTABLE DRUGS	8,338.16

TOTAL NUMBER OF CLAIMS 1,040

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 18:07:47  
 Page: 5

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,084.74	2,694.04	OTHER LAB	88,382.77	321.36
MED/SURG SUPPLY	30,349.32	2,111.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,368.87	1,760.23	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	154,563.19	13,582.82	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	111.41	FEE SCHEDULE LAB	152,415.00	45,508.50
EKG/ECG	15,167.51	356.52	MRI SERVICES	54,565.37	1,612.65
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,304.44	6,713.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,820.66	471.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,527.48	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	255,054.72	6,013.93	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,310.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,748.21	3,862.64
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	524.26	707.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	118.10
OTHER IMAGING SERVICE	21,239.27	1,124.76			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,354.47	1,831.77			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,382.00	3,588.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,565.72	0.00			
			TOTAL ANCILLARY	947,728.52	92,491.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	947,728.52	92,491.00

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3300	2212046011161	12/20/11 - 12/20/11	02/20/12	0.00	33.43	0.00	0.00	0.00
3300	2212250008464	07/19/12 - 07/19/12	09/10/12	0.00	84.67	0.00	0.00	0.00
TOTAL				0.00	118.10	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL  
101 LAKE OCONEE PARKWAY  
EATONTON,GA 31024-6054

PROVIDER NUMBER  
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,691.50	ADJUSTMENTS	0.00
COVERED CHARGES	9,006.21	CONTRACTUAL ALLOW	1,987.14
NON-COVERD CHARGES	1,685.29	TOTAL MEDICAID LIAB	7,019.07
		LESS: COB	6,998.07
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	741.00	0.00	OTHER LAB	1,221.17	0.00
MED/SURG SUPPLY	265.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	155.33	423.13	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,432.72	556.10
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	2,033.78	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	131.04	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,024.96	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,117.86	342.86	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	102.00	363.20
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	278.52	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,006.21	1,685.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,006.21	1,685.29

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	97,169.51	ADJUSTMENTS	471.86
COVERED CHARGES	90,861.41	CONTRACTUAL ALLOW	83,361.19
NON-COVERD CHARGES	6,308.10	TOTAL MEDICAID LIAB	7,500.22
		LESS: COB	0.00
		LESS: COPAYMENT	261.00
		REIMBURSEMENT	7,239.22
		TOTAL NUMBER OF CLAIMS	161

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,195.08	725.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,103.99	110.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,203.91	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,507.26	2,249.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,057.28	2,387.22
EKG/ECG	701.85	0.00	MRI SERVICES	7,746.68	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	364.98	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,674.49	398.55	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	2,802.01	99.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,892.82	338.50			
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	611.06	0.00			
			TOTAL ANCILLARY	90,861.41	6,308.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,861.41	6,308.10

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	729.86	ADJUSTMENTS	0.00
COVERED CHARGES	729.86	CONTRACTUAL ALLOW	256.33
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	473.53
		LESS: COB	467.53
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	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	592.86	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	117.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	729.86	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	729.86	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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL  
101 LAKE OCONEE PARKWAY  
EATONTON,GA 31024-6054

PROVIDER NUMBER  
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,324.98	ADJUSTMENTS	8,973.80
COVERED CHARGES	38,868.91	CONTRACTUAL ALLOW	25,403.71
NON-COVERD CHARGES	3,456.07	TOTAL MEDICAID LIAB	13,465.20
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	13,459.20

TOTAL NUMBER OF CLAIMS 3

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,775.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,825.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110.34	365.28	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	620.52	295.66
EKG/ECG	0.00	72.41	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,632.09	1,632.09	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,434.28	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	934.09	1,078.63	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,290.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	276.00	12.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	9,970.73	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,868.91	3,456.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,868.91	3,456.07



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:08:17  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,184,469.51	ADJUSTMENTS	8,196.85
COVERED CHARGES	1,164,657.51	CONTRACTUAL ALLOW	364,211.18
NON-COVERD CHARGES	19,812.00	TOTAL MEDICAID LIAB	800,446.33
		LESS: COB	4,568.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	795,877.59

TOTAL NUMBER OF ADMISSIONS 133

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	317		0	151,870.00		10,400.00
ROUTINE NURSERY	33		0	15,770.00		730.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	350		0	167,640.00		11,130.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	44		0	52,800.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	44		0	52,800.00		0.00
TOTAL ACCOMODATIONS	394		0	220,440.00		11,130.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:08:17  
 Page: 2

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	184,787.42	0.00	OTHER LAB	7,022.40	0.00
MED/SURG SUPPLY	70,762.60	20.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	153,795.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,914.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,983.44	825.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,520.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,291.00	0.00	MRI SERVICES	26,735.50	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,221.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,622.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,433.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,488.50	0.00	AMBULANCE	0.00	2,657.00
GI SERVICES	8,611.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,095.22	0.00	SPECIAL SERVICES	0.00	3,645.00
RECOVERY ROOM	9,839.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	139.50	0.00	INJECTABLE DRUGS	120,627.20	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	50.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,448.53	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,112.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,964.00	1,535.00			
AUDIOLOGY	3,724.00	0.00			
CARDIOLOGY	24,998.30	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,030.00	0.00			
			TOTAL ANCILLARY	944,217.51	8,682.00
			TOTAL ACCOMODATIONS	220,440.00	11,130.00
			TOTAL CHARGES	1,164,657.51	19,812.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:08:30  
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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 04/01/11 THROUGH 03/31/12  
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: 09/24/2013  
Run Time: 18:08:31  
Page: 4

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,757,442.97	ADJUSTMENTS	48,030.96
COVERED CHARGES	1,548,830.16	CONTRACTUAL ALLOW	1,170,503.30
NON-COVERD CHARGES	208,612.81	TOTAL MEDICAID LIAB	378,326.86
		LESS: COB	357.26
		LESS: COPAYMENT	2,661.53
		REIMBURSEMENT	375,308.07
		ALL OTHER	311,596.99
		FEE SCHEDULE-LAB	59,079.07
		INJECTABLE DRUGS	4,632.01
		TOTAL NUMBER OF CLAIMS	2,110

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 18:08:31  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,532.82	5,429.50	OTHER LAB	13,486.20	3,210.00
MED/SURG SUPPLY	39,416.05	508.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	123.50	EDUCATION & TRAINING	0.00	1.00
RADIOLOGY-DIAGNOSTIC	83,540.80	1,206.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	123,926.52	20,721.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,230.00	1,800.00	FEE SCHEDULE LAB	330,311.10	110,388.43
EKG/ECG	15,858.00	1,780.00	MRI SERVICES	114,573.50	9,949.50
IV THERAPY	7,990.50	893.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	101,516.50	18,374.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,263.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,269.00	2,705.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,767.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	68,409.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	260,224.87	2,873.36	SPECIAL SERVICES	0.00	243.00
RECOVERY ROOM	22,603.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,002.20	16,087.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27,961.50	2,280.50	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	67,943.20	2,367.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,587.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,350.20	6,084.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,996.50	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	40,657.00	0.00			
			TOTAL ANCILLARY	1,548,830.16	208,612.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,548,830.16	208,612.81

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

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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,364.80	ADJUSTMENTS	0.00
COVERED CHARGES	27,920.90	CONTRACTUAL ALLOW	14,920.92
NON-COVERD CHARGES	7,443.90	TOTAL MEDICAID LIAB	12,999.98
		LESS: COB	12,999.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	770.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	804.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	672.60	98.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,094.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,386.00	108.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,457.30	4,793.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	109.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,776.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,758.74	195.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	893.00	155.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	739.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	355.00	0.00			
			TOTAL ANCILLARY	27,920.90	7,443.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,920.90	7,443.90



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: 09/24/2013  
Run Time: 18:09:36  
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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,193.65	ADJUSTMENTS	778.36
COVERED CHARGES	62,973.35	CONTRACTUAL ALLOW	56,392.06
NON-COVERD CHARGES	6,220.30	TOTAL MEDICAID LIAB	6,581.29
		LESS: COB	0.00
		LESS: COPAYMENT	264.03
		REIMBURSEMENT	6,317.26
		TOTAL NUMBER OF CLAIMS	136

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,096.65	61.50	OTHER LAB	0.00	308.00
MED/SURG SUPPLY	235.00	6.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,296.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,590.40	2,543.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,776.50	2,897.00
EKG/ECG	600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	484.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,345.00	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	2,830.00	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	369.60	369.60			
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	350.00	0.00			
			TOTAL ANCILLARY	62,973.35	6,220.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	62,973.35	6,220.30

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: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	440.00	ADJUSTMENTS	0.00
COVERED CHARGES	440.00	CONTRACTUAL ALLOW	239.40
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	200.60
		LESS: COB	200.60
		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: 09/24/2013  
 Run Time: 18:09:40  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 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	112.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	440.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	440.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/11	THROUGH	03/31/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/11	THROUGH	03/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:09:49  
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
 196 RIDGECREST CIR  
 CLAYTON,GA 30525-4111

PROVIDER NUMBER 000001559A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	282,628.97	ADJUSTMENTS	0.00
COVERED CHARGES	255,507.97	CONTRACTUAL ALLOW	117,243.70
NON-COVERD CHARGES	27,121.00	TOTAL MEDICAID LIAB	138,264.27
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	138,264.27
		TOTAL NUMBER OF ADMISSIONS	24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	95		0	36,675.00		26,100.00
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	95		0	36,675.00		26,100.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	95		0	36,675.00		26,100.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
 196 RIDGECREST CIR  
 CLAYTON,GA 30525-4111

PROVIDER NUMBER  
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,636.40	0.00	OTHER LAB	1,685.00	0.00
MED/SURG SUPPLY	24,496.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	53,620.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,950.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,208.00	1,021.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,620.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	370.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,014.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	118.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,764.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,035.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,031.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,552.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,231.72	0.00			
			TOTAL ANCILLARY	218,832.97	1,021.00
			TOTAL ACCOMODATIONS	36,675.00	26,100.00
			TOTAL CHARGES	255,507.97	27,121.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	714,032.39	ADJUSTMENTS	4,068.07
COVERED CHARGES	598,882.73	CONTRACTUAL ALLOW	381,842.05
NON-COVERD CHARGES	115,149.66	TOTAL MEDICAID LIAB	217,040.68
		LESS: COB	271.39
		LESS: COPAYMENT	1,083.00
		REIMBURSEMENT	215,686.29
		ALL OTHER	198,642.32
		FEE SCHEDULE-LAB	16,987.80
		INJECTABLE DRUGS	56.17

TOTAL NUMBER OF CLAIMS 755

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 18:09:50  
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
 196 RIDGECREST CIR  
 CLAYTON,GA 30525-4111

PROVIDER NUMBER  
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,642.75	8,092.40	OTHER LAB	6,311.00	0.00
MED/SURG SUPPLY	34,201.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,764.00	1,171.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,061.00	28,031.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,273.00	5,349.00	FEE SCHEDULE LAB	139,207.00	30,410.00
EKG/ECG	8,960.00	140.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,497.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,033.50	33,769.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,666.00	463.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	566.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	117,161.60	306.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,131.37	3,301.76
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	1,000.00
OTHER IMAGING SERVICE	12,411.60	290.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,672.00	1,672.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,472.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,190.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,661.68	1,154.00			
			TOTAL ANCILLARY	598,882.73	115,149.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	598,882.73	115,149.66

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: 09/24/2013  
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012341015638	11/30/12 - 11/30/12	12/10/12	0.00	1,000.00	0.00	0.00	0.00
TOTAL				0.00	1,000.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,071.53	ADJUSTMENTS	0.00
COVERED CHARGES	9,221.03	CONTRACTUAL ALLOW	2,268.48
NON-COVERD CHARGES	850.50	TOTAL MEDICAID LIAB	6,952.55
		LESS: COB	6,941.18
		LESS: COPAYMENT	11.37
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
 196 RIDGECREST CIR  
 CLAYTON,GA 30525-4111

PROVIDER NUMBER  
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,127.43	0.00	OTHER LAB	563.00	0.00
MED/SURG SUPPLY	462.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	736.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,021.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,932.00	840.00
EKG/ECG	420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,660.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	266.00	10.50			
			TOTAL ANCILLARY	9,221.03	850.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,221.03	850.50

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: 09/24/2013  
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PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,363.77	ADJUSTMENTS	47.00
COVERED CHARGES	30,828.93	CONTRACTUAL ALLOW	27,828.93
NON-COVERD CHARGES	1,534.84	TOTAL MEDICAID LIAB	3,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,907.00
		TOTAL NUMBER OF CLAIMS	60

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:10:06  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
 196 RIDGECREST CIR  
 CLAYTON,GA 30525-4111

PROVIDER NUMBER  
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,486.07	235.53	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	565.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,732.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,169.00	1,095.00
EKG/ECG	140.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	212.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,074.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	204.31
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	450.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,828.93	1,534.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,828.93	1,534.84



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: 09/24/2013  
Run Time: 18:10:07  
Page: 11

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:10:14  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,086,381.31	ADJUSTMENTS	464,517.30
COVERED CHARGES	28,689,646.72	CONTRACTUAL ALLOW	21,793,479.62
NON-COVERD CHARGES	396,734.59	TOTAL MEDICAID LIAB	6,896,167.10
		LESS: COB	35,057.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,861,109.33

TOTAL NUMBER OF ADMISSIONS 571

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,958		0	1,490,832.00		201,182.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,958		0	1,490,832.00		201,182.00
SPECIAL CARE SERVICES						
CCU	241		0	366,046.00		0.00
ICU	240		0	386,241.00		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		23	0.00		18,009.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	481		23	752,287.00		18,009.00
TOTAL ACCOMODATIONS	3,439		23	2,243,119.00		219,191.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,885,673.68	1,298.73	OTHER LAB	177,655.00	0.00
MED/SURG SUPPLY	2,641,443.75	13,276.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,807,572.00	3,395.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	799,445.00	0.00	OTHER THERAPEUTIC SVC	0.00	716.00
CT SCAN	1,210,982.00	33,171.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	299,943.00	1,482.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	316,934.00	0.00	MRI SERVICES	289,478.00	0.00
IV THERAPY	60,103.00	194.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,582,454.00	8,040.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,036,431.00	1,071.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	414,746.00	0.00	AMBULANCE	0.00	2,906.00
GI SERVICES	74,743.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	915,788.00	120.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	237,711.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	151,482.00	0.00	INJECTABLE DRUGS	2,136,874.29	16,026.86
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	230,512.00	404.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	97,071.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	128,592.00	8,226.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,085.00	1,004.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,161,293.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	117,519.00	2,765.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	279,666.00	26,350.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	332,840.00	57,098.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,985,179.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,682.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,630.00	0.00			
			TOTAL ANCILLARY	26,446,527.72	177,543.59
			TOTAL ACCOMODATIONS	2,243,119.00	219,191.00
			TOTAL CHARGES	28,689,646.72	396,734.59

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,591.72	ADJUSTMENTS	0.00
COVERED CHARGES	95,538.72	CONTRACTUAL ALLOW	90,378.84
NON-COVERD CHARGES	5,053.00	TOTAL MEDICAID LIAB	5,159.88
		LESS: COB	5,159.88
		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	22		0	11,088.00		5,053.00
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	22		0	11,088.00		5,053.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	11,088.00		5,053.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,493.97	0.00	OTHER LAB	977.00	0.00
MED/SURG SUPPLY	4,068.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,821.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,688.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,468.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,543.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	377.00	0.00	MRI SERVICES	8,578.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,420.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,167.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,199.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,836.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,869.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,321.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	624.00	0.00			
			TOTAL ANCILLARY	84,450.72	0.00
			TOTAL ACCOMODATIONS	11,088.00	5,053.00
			TOTAL CHARGES	95,538.72	5,053.00

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: 09/24/2013  
Run Time: 18:10:30  
Page: 5

REDMOND REGIONAL MEDICAL CENTER  
501 REDMOND RD  
ROME,GA 30165-1415

PROVIDER NUMBER  
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,075,703.80	ADJUSTMENTS	274,881.75
COVERED CHARGES	12,003,474.11	CONTRACTUAL ALLOW	9,810,129.63
NON-COVERD CHARGES	2,072,229.69	TOTAL MEDICAID LIAB	2,193,344.48
		LESS: COB	3,222.84
		LESS: COPAYMENT	4,797.58
		REIMBURSEMENT	2,185,324.06
		ALL OTHER	2,040,122.89
		FEE SCHEDULE-LAB	109,970.15
		INJECTABLE DRUGS	35,231.02

TOTAL NUMBER OF CLAIMS 3,180



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	293,982.56	507.83	OTHER LAB	59,464.00	0.00
MED/SURG SUPPLY	789,969.20	30.00	RECREATIONAL THERAPY	1,253.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	111.00	0.00
RADIOLOGY-DIAGNOSTIC	810,311.00	41,441.00	OTHER THERAPEUTIC SVC	0.00	4,397.00
CT SCAN	1,409,949.00	44,976.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	78,431.00	61,204.00	FEE SCHEDULE LAB	2,639,745.80	646,986.80
EKG/ECG	240,758.00	6,409.00	MRI SERVICES	187,028.00	24,420.00
IV THERAPY	283,239.18	20,864.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	921,972.13	203,464.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,917.00	181,728.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	314,473.00	8,930.00	AMBULANCE	0.00	0.00
GI SERVICES	105,209.01	22,160.99	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,999,987.00	8,964.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	268,228.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	202,859.25	125,386.34
RADIOLOGY THERAPEUTIC	8,864.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,414.00	36,125.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,565.00	15,418.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	97,742.00	1,015.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,752.00	281,339.00
LITHOTRIPSY	12,523.50	37,570.50	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	123,595.00	6,727.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72,405.00	2,892.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	279,663.00	96,247.91			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	500,749.50	188,215.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,128.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	189,185.98	4,810.00			
			TOTAL ANCILLARY	12,003,474.11	2,072,229.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,003,474.11	2,072,229.69

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

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	247,035.73	ADJUSTMENTS	0.00
COVERED CHARGES	113,542.32	CONTRACTUAL ALLOW	31,236.17
NON-COVERD CHARGES	133,493.41	TOTAL MEDICAID LIAB	82,306.15
		LESS: COB	82,262.24
		LESS: COPAYMENT	43.91
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,926.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,398.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,430.00	2,822.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,606.00	13,563.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	374.00	9,564.00	FEE SCHEDULE LAB	23,834.00	5,985.00
EKG/ECG	2,881.00	0.00	MRI SERVICES	3,989.00	4,612.00
IV THERAPY	1,654.00	179.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,760.00	25,776.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	396.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,835.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,167.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,888.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,352.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	168.02	2,504.41
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	235.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	54,933.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,884.00	1,661.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	11,659.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	113,542.32	133,493.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	113,542.32	133,493.41

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	899,506.03	ADJUSTMENTS	2,017.69
COVERED CHARGES	835,683.87	CONTRACTUAL ALLOW	803,574.31
NON-COVERD CHARGES	63,822.16	TOTAL MEDICAID LIAB	32,109.56
		LESS: COB	0.00
		LESS: COPAYMENT	1,335.05
		REIMBURSEMENT	30,774.51
		TOTAL NUMBER OF CLAIMS	574

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,441.87	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,569.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,047.00	519.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,493.00	8,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	209,755.00	49,937.00
EKG/ECG	15,133.00	377.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,726.00	1,942.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,968.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	422,784.00	55.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,642.00	2,156.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,125.00	368.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	835,683.87	63,822.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	835,683.87	63,822.16

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,659.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,623.00	CONTRACTUAL ALLOW	8,601.22
NON-COVERD CHARGES	5,036.00	TOTAL MEDICAID LIAB	6,021.78
		LESS: COB	6,006.78
		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: 09/24/2013  
 Run Time: 18:11:37  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	257.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,044.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,938.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,120.00	1,098.00
EKG/ECG	350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	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	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,688.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,623.00	5,036.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,623.00	5,036.00

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER  
501 REDMOND RD  
ROME,GA 30165-1415

PROVIDER NUMBER  
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,544,413.02	ADJUSTMENTS	21,158.00
COVERED CHARGES	2,278,843.72	CONTRACTUAL ALLOW	2,023,644.89
NON-COVERD CHARGES	265,569.30	TOTAL MEDICAID LIAB	255,198.83
		LESS: COB	7,426.61
		LESS: COPAYMENT	366.39
		REIMBURSEMENT	247,405.83

TOTAL NUMBER OF CLAIMS 47



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,531.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	173,299.00	167.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,228.00	6,126.00	OTHER THERAPEUTIC SVC	0.00	166.00
CT SCAN	22,642.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,684.60	13,583.40
EKG/ECG	16,641.00	1,858.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,189.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	454,273.00	5,130.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,239.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,804.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,632.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	89,978.46	24,639.26
RADIOLOGY THERAPEUTIC	1,203.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	86,571.00	60.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	665,998.00	189,409.00
LITHOTRIPSY	132,751.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,713.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,046.00	9,181.48			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	417,392.84	15,135.16			
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	31,827.69	114.00			
			TOTAL ANCILLARY	2,278,843.72	265,569.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,278,843.72	265,569.30

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: 09/24/2013  
Run Time: 18:11:40  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER  
501 REDMOND RD  
ROME,GA 30165-1415

PROVIDER NUMBER  
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,552.27	ADJUSTMENTS	0.00
COVERED CHARGES	67,276.92	CONTRACTUAL ALLOW	1,941.85
NON-COVERD CHARGES	275.35	TOTAL MEDICAID LIAB	65,335.07
		LESS: COB	65,332.07
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	770.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,200.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	558.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	754.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	132.69	275.35
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	52,971.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,891.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	67,276.92	275.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,276.92	275.35

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER 000001603A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,295,399.14	ADJUSTMENTS	1,812,583.12
COVERED CHARGES	24,841,761.17	CONTRACTUAL ALLOW	17,244,973.43
NON-COVERD CHARGES	453,637.97	TOTAL MEDICAID LIAB	7,596,787.74
		LESS: COB	82,828.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,513,959.36

TOTAL NUMBER OF ADMISSIONS 1,017

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,153		0	1,067,632.00		33,584.00
ROUTINE NURSERY	760		0	1,205,368.00		39,308.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,913		0	2,273,000.00		72,892.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,181		0	1,331,768.00		0.00
NICU	708		0	3,349,050.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,889		0	4,680,818.00		0.00
TOTAL ACCOMODATIONS	4,802		0	6,953,818.00		72,892.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,852,391.74	7,647.04	OTHER LAB	149,590.00	0.00
MED/SURG SUPPLY	1,300,319.50	25,153.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,981,616.11	24,873.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	332,345.00	0.00	OTHER THERAPEUTIC SVC	0.00	221.00
CT SCAN	825,370.00	3,672.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,341.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	110,095.00	0.00	MRI SERVICES	252,562.00	0.00
IV THERAPY	279,784.33	5,294.00	PROFESSIONAL FEES	0.00	2,182.00
OPERATING ROOM	1,281,363.86	13,371.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,477,551.00	57,004.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,011,584.00	15,848.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	364,380.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	105,343.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	700,056.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	322,284.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	187,614.00	0.00	INJECTABLE DRUGS	1,086,460.63	32.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,491.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,985.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	337,211.00	35,115.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,278.00	1,046.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	520,684.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	19,649.00
OTHER IMAGING SERVICE	249,298.00	0.00			
BLOOD	0.00	350.00			
BLOOD STORAGE & PRO.	455,905.00	168,453.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	86,843.00	0.00			
AUDIOLOGY	21,761.00	0.00			
CARDIOLOGY	388,574.00	835.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,278.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,584.00	0.00			
			TOTAL ANCILLARY	17,887,943.17	380,745.97
			TOTAL ACCOMODATIONS	6,953,818.00	72,892.00
			TOTAL CHARGES	24,841,761.17	453,637.97

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: 09/24/2013  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012184039015	03/21/12 - 03/28/12	07/09/12	0.00	2,074.00	0.00	0.00	0.00
615	9112191012693	11/15/11 - 11/17/11	07/30/12	0.00	2,074.00	0.00	1,650.26	0.00
614	2012235074898	08/07/12 - 08/09/12	08/27/12	0.00	2,335.00	0.00	0.00	0.00
614	2012236076631	08/12/12 - 08/14/12	08/27/12	0.00	2,442.00	0.00	0.00	0.00
615	2012282144977	09/28/12 - 10/02/12	10/22/12	0.00	2,074.00	0.00	0.00	0.00
614	2012283038268	09/15/12 - 10/02/12	10/15/12	0.00	2,335.00	0.00	0.00	0.00
618	2012283038268	09/15/12 - 10/02/12	10/15/12	0.00	1,906.00	0.00	0.00	0.00
615	2013064043208	11/11/11 - 11/18/11	03/11/13	0.00	2,074.00	0.00	0.00	0.00
614	2013130044265	09/13/12 - 09/25/12	05/20/13	0.00	2,335.00	0.00	0.00	0.00
TOTAL				0.00	19,649.00	0.00	1,650.26	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: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER 000001603A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	727,248.91	ADJUSTMENTS	0.00
COVERED CHARGES	715,952.91	CONTRACTUAL ALLOW	464,199.77
NON-COVERD CHARGES	11,296.00	TOTAL MEDICAID LIAB	251,753.14
		LESS: COB	251,753.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	81		0	40,296.00		1,500.00
ROUTINE NURSERY	22		0	70,064.00		97.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	103		0	110,360.00		1,597.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	25		0	29,834.00		0.00
NICU	29		0	137,373.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	54		0	167,207.00		0.00
TOTAL ACCOMODATIONS	157		0	277,567.00		1,597.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,969.43	0.00	OTHER LAB	3,726.00	0.00
MED/SURG SUPPLY	42,127.50	47.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	110,763.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,880.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,335.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	623.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,960.00	0.00	MRI SERVICES	9,750.00	0.00
IV THERAPY	3,786.00	0.00	PROFESSIONAL FEES	0.00	932.00
OPERATING ROOM	14,521.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,213.00	2,576.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,624.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,123.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,615.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,934.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,222.00	0.00	INJECTABLE DRUGS	29,813.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	366.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	592.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	998.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,074.00
OTHER IMAGING SERVICE	11,807.00	0.00			
BLOOD	0.00	350.00			
BLOOD STORAGE & PRO.	3,836.00	3,720.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	130.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,654.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,017.00	0.00			
			TOTAL ANCILLARY	438,385.91	9,699.00
			TOTAL ACCOMODATIONS	277,567.00	1,597.00
			TOTAL CHARGES	715,952.91	11,296.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212142007689	03/02/12 - 03/08/12	05/28/12	0.00	2,074.00	0.00	11,985.06	0.00
TOTAL				0.00	2,074.00	0.00	11,985.06	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: 09/24/2013  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,700,536.76	ADJUSTMENTS	606,372.39
COVERED CHARGES	11,708,287.02	CONTRACTUAL ALLOW	9,471,209.36
NON-COVERD CHARGES	992,249.74	TOTAL MEDICAID LIAB	2,237,077.66
		LESS: COB	16,041.95
		LESS: COPAYMENT	3,755.46
		REIMBURSEMENT	2,217,280.25
		ALL OTHER	2,033,314.34
		FEE SCHEDULE-LAB	148,634.58
		INJECTABLE DRUGS	35,331.33

TOTAL NUMBER OF CLAIMS 4,733

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	518,252.87	4,257.69	OTHER LAB	125,207.00	4,094.00
MED/SURG SUPPLY	366,940.17	20,055.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	98.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	335,304.00	6,470.00	OTHER THERAPEUTIC SVC	0.00	1,636.00
CT SCAN	1,528,286.00	50,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,280.00	2,645.00	FEE SCHEDULE LAB	2,396,893.80	432,342.80
EKG/ECG	141,366.00	1,960.00	MRI SERVICES	270,663.00	12,646.00
IV THERAPY	556,256.99	99,979.00	PROFESSIONAL FEES	0.00	39.00
OPERATING ROOM	680,277.58	93,369.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,893.00	21,680.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	243,336.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	146,883.00	17,935.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,458,807.00	3,604.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	244,418.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	130,490.69	78,613.19
RADIOLOGY THERAPEUTIC	53,573.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,384.00	75.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	367.00	734.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	28,121.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	42,048.00	5,538.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,169.24	64,262.87
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,391.00
OTHER IMAGING SERVICE	470,576.00	22,193.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	46,663.00	1,860.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	94,942.00	5,600.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	301,928.68	8,378.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,068.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	431,013.00	749.00			
			TOTAL ANCILLARY	11,708,287.02	992,249.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,708,287.02	992,249.74

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212033003655	01/19/12 - 01/19/12	02/06/12	0.00	2,391.00	0.00	650.95	0.00
TOTAL				0.00	2,391.00	0.00	650.95	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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	152,201.36	ADJUSTMENTS	0.00
COVERED CHARGES	126,990.94	CONTRACTUAL ALLOW	84,852.00
NON-COVERD CHARGES	25,210.42	TOTAL MEDICAID LIAB	42,138.94
		LESS: COB	42,112.85
		LESS: COPAYMENT	26.09
		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

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,506.91	125.97	OTHER LAB	3,708.00	530.00
MED/SURG SUPPLY	560.00	49.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,850.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,399.00	3,848.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,776.00	4,610.00
EKG/ECG	490.00	0.00	MRI SERVICES	0.00	6,318.00
IV THERAPY	7,830.00	404.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	747.00	218.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,634.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,907.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161.03	1,390.45
RADIOLOGY THERAPEUTIC	310.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	856.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,790.00	5,832.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,501.00	251.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,599.00	0.00			
			TOTAL ANCILLARY	126,990.94	25,210.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	126,990.94	25,210.42

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	735,121.18	ADJUSTMENTS	1,786.01
COVERED CHARGES	699,175.21	CONTRACTUAL ALLOW	665,614.97
NON-COVERD CHARGES	35,945.97	TOTAL MEDICAID LIAB	33,560.24
		LESS: COB	0.00
		LESS: COPAYMENT	855.02
		REIMBURSEMENT	32,705.22
		TOTAL NUMBER OF CLAIMS	600

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,432.91	341.58	OTHER LAB	20,500.00	0.00
MED/SURG SUPPLY	3,891.99	738.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,737.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,047.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	175,862.00	26,199.00
EKG/ECG	5,575.00	0.00	MRI SERVICES	3,541.00	0.00
IV THERAPY	34,817.00	2,997.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,971.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	999.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,176.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	338,925.00	173.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,753.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,029.91	3,086.89
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	16,028.00	2,410.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,889.00	0.00			
			TOTAL ANCILLARY	699,175.21	35,945.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	699,175.21	35,945.97



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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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,021.40	ADJUSTMENTS	0.00
COVERED CHARGES	32,033.94	CONTRACTUAL ALLOW	23,835.82
NON-COVERD CHARGES	4,987.46	TOTAL MEDICAID LIAB	8,198.12
		LESS: COB	8,177.12
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	25

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	602.88	89.50	OTHER LAB	2,173.00	295.00
MED/SURG SUPPLY	65.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	332.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,579.00	1,926.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,762.00	221.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,550.00	221.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161.06	310.96
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	2,658.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,033.94	4,987.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,033.94	4,987.46

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

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,430,454.90	ADJUSTMENTS	125,289.00
COVERED CHARGES	1,325,240.71	CONTRACTUAL ALLOW	1,130,857.15
NON-COVERD CHARGES	105,214.19	TOTAL MEDICAID LIAB	194,383.56
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	194,158.56

TOTAL NUMBER OF CLAIMS 39

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

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	301,511.47	0.00	OTHER LAB	310.00	0.00
MED/SURG SUPPLY	162,857.12	11,649.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,957.00	4,032.00	OTHER THERAPEUTIC SVC	0.00	210.00
CT SCAN	16,584.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	536.00	FEE SCHEDULE LAB	62,522.00	5,494.00
EKG/ECG	2,683.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	44,933.00	6,871.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	216,170.37	28,255.61	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,532.00	218.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,887.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,271.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,315.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	103,420.75	5,098.33
RADIOLOGY THERAPEUTIC	112,781.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	202.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	475.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	722.00	39,898.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	169.00
OTHER IMAGING SERVICE	4,009.00	1,651.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,082.00	930.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,223.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	94,111.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,884.00	0.00			
			TOTAL ANCILLARY	1,325,240.71	105,214.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,325,240.71	105,214.19

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

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9637	5912180000870	11/29/11 - 11/29/11	07/02/12	0.00	169.00	0.00	0.00	0.00
TOTAL				0.00	169.00	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

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,646,645.00	ADJUSTMENTS	509,686.96
COVERED CHARGES	27,308,825.00	CONTRACTUAL ALLOW	22,528,855.57
NON-COVERD CHARGES	337,820.00	TOTAL MEDICAID LIAB	4,779,969.43
		LESS: COB	26,189.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,753,780.15

TOTAL NUMBER OF ADMISSIONS 634

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,009		0	2,235,795.00		130,665.00
ROUTINE NURSERY	145		0	161,620.00		18,090.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,154		0	2,397,415.00		148,755.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	393		0	1,169,175.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	393		0	1,169,175.00		0.00
TOTAL ACCOMODATIONS	2,547		0	3,566,590.00		148,755.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,881,395.50	566.50	OTHER LAB	95,304.25	0.00
MED/SURG SUPPLY	1,341,247.75	9,185.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,340,134.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	597,298.50	0.00	OTHER THERAPEUTIC SVC	0.00	258.50
CT SCAN	1,377,034.00	43,404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	132,424.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	274,822.50	0.00	MRI SERVICES	416,985.00	0.00
IV THERAPY	86,310.25	3,108.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,499,274.50	25,249.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	345,537.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,390,638.50	4,850.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	800,809.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	109,724.25	4,316.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	833,298.50	4,052.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	274,284.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	127,368.25	0.00	INJECTABLE DRUGS	3,519,494.80	0.00
RADIOLOGY THERAPEUTIC	129,582.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	30,492.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,583.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	9,473.75	1,722.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	710.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	368,350.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	190,269.75	19,524.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	173,636.00	37,982.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	237,830.00	26,444.75			
AUDIOLOGY	0.00	8,400.00			
CARDIOLOGY	1,063,998.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,759.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,163.45	0.00			
			TOTAL ANCILLARY	23,742,235.00	189,065.00
			TOTAL ACCOMODATIONS	3,566,590.00	148,755.00
			TOTAL CHARGES	27,308,825.00	337,820.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER  
 960 JOE FRANK HARRIS PKWY SE  
 CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER 000001625A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	367,286.00	ADJUSTMENTS	0.00
COVERED CHARGES	363,521.00	CONTRACTUAL ALLOW	246,359.43
NON-COVERD CHARGES	3,765.00	TOTAL MEDICAID LIAB	117,161.57
		LESS: COB	117,161.57
		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	35		0	38,320.00		3,245.00
ROUTINE NURSERY	3		0	3,270.00		420.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	38		0	41,590.00		3,665.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	11,900.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	11,900.00		0.00
TOTAL ACCOMODATIONS	42		0	53,490.00		3,665.00

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 10/01/11 THROUGH 09/30/12  
 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	40,693.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,645.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	71,474.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,505.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,597.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	719.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,124.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,685.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,050.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,547.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,117.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,423.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,527.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,838.25	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	193.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,992.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,300.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	100.00			
CARDIOLOGY	32,238.50	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	1,254.75	0.00			
			TOTAL ANCILLARY	310,031.00	100.00
			TOTAL ACCOMODATIONS	53,490.00	3,665.00
			TOTAL CHARGES	363,521.00	3,765.00

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,981,088.52	ADJUSTMENTS	223,785.68
COVERED CHARGES	17,621,467.68	CONTRACTUAL ALLOW	14,414,412.97
NON-COVERD CHARGES	1,359,620.84	TOTAL MEDICAID LIAB	3,207,054.71
		LESS: COB	9,864.16
		LESS: COPAYMENT	3,978.47
		REIMBURSEMENT	3,193,212.08
		ALL OTHER	2,987,293.70
		FEE SCHEDULE-LAB	181,009.63
		INJECTABLE DRUGS	24,908.75

TOTAL NUMBER OF CLAIMS 4,721

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
960 JOE FRANK HARRIS PKWY SE	000001625A	SERVICE DATES	10/01/11	THROUGH	09/30/12
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	628,430.25	654.25	OTHER LAB	98,584.75	0.00
MED/SURG SUPPLY	646,020.75	272.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,027,268.00	28,741.25	OTHER THERAPEUTIC SVC	0.00	626.00
CT SCAN	2,479,987.75	127,666.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,934,266.85	592,618.52
EKG/ECG	298,117.75	6,421.25	MRI SERVICES	437,197.50	12,566.00
IV THERAPY	415,764.75	67,115.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	799,649.45	166,711.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,337.50	14,662.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	62,750.50	4,445.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	795,545.75	2,931.00	AMBULANCE	0.00	0.00
GI SERVICES	282,966.03	23,731.94	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,165,319.00	44,400.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	424,745.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	232,459.55	129,536.75
RADIOLOGY THERAPEUTIC	244,406.25	9,795.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	570.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,149.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,341.00	2,741.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,802.00	20,306.75
LITHOTRIPSY	20,300.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	591,927.00	42,101.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	43,728.25	678.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	391,218.00	42,566.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	321,722.50	12,621.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,486.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149,124.55	3,991.50			
			TOTAL ANCILLARY	17,621,467.68	1,359,620.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,621,467.68	1,359,620.84

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	296,475.75	ADJUSTMENTS	0.00
COVERED CHARGES	248,982.00	CONTRACTUAL ALLOW	178,255.92
NON-COVERD CHARGES	47,493.75	TOTAL MEDICAID LIAB	70,726.08
		LESS: COB	70,645.08
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 67

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,960.00	0.00	OTHER LAB	951.25	0.00
MED/SURG SUPPLY	12,985.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,278.75	5,111.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,258.00	25,720.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	55,344.00	8,425.50
EKG/ECG	3,186.00	0.00	MRI SERVICES	9,278.00	3,588.00
IV THERAPY	21,055.25	1,540.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,067.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	782.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	764.00	223.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,467.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,611.00	183.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,175.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	414.25	1,760.75
RADIOLOGY THERAPEUTIC	17,656.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,043.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,057.75	1.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,812.50	157.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,554.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	63.25	0.00			
			TOTAL ANCILLARY	248,982.00	47,493.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	248,982.00	47,493.75

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,424,263.10	ADJUSTMENTS	1,553.25
COVERED CHARGES	1,364,969.10	CONTRACTUAL ALLOW	1,326,187.38
NON-COVERD CHARGES	59,294.00	TOTAL MEDICAID LIAB	38,781.72
		LESS: COB	0.00
		LESS: COPAYMENT	1,323.10
		REIMBURSEMENT	37,458.62
		TOTAL NUMBER OF CLAIMS	695

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 10/01/11 THROUGH 09/30/12  
 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	27,154.60	0.00	OTHER LAB	5,033.75	0.00
MED/SURG SUPPLY	11,089.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,559.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	116,405.25	3,147.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	361,709.25	32,751.75
EKG/ECG	23,895.00	0.00	MRI SERVICES	11,872.50	3,957.50
IV THERAPY	30,768.50	5,198.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,002.75	669.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	612,135.50	246.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,016.50	4,545.00
RADIOLOGY THERAPEUTIC	19,858.25	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	48,432.25	7,463.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,315.50			
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	3,036.00	0.00			
			TOTAL ANCILLARY	1,364,969.10	59,294.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,364,969.10	59,294.00



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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,876.25	ADJUSTMENTS	0.00
COVERED CHARGES	21,426.50	CONTRACTUAL ALLOW	14,768.45
NON-COVERD CHARGES	449.75	TOTAL MEDICAID LIAB	6,658.05
		LESS: COB	6,655.05
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CARTERSVILLE MEDICAL CENTER  
 960 JOE FRANK HARRIS PKWY SE  
 CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER  
 000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	909.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	193.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	376.75	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	9,869.50	156.75
EKG/ECG	531.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,110.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,427.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.25	293.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,426.50	449.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,426.50	449.75

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CARTERSVILLE MEDICAL CENTER  
960 JOE FRANK HARRIS PKWY SE  
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER  
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,418,225.34	ADJUSTMENTS	45,432.72
COVERED CHARGES	3,195,647.21	CONTRACTUAL ALLOW	2,710,318.37
NON-COVERD CHARGES	222,578.13	TOTAL MEDICAID LIAB	485,328.84
		LESS: COB	2,334.29
		LESS: COPAYMENT	1,037.16
		REIMBURSEMENT	481,957.39

TOTAL NUMBER OF CLAIMS 96

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 10/01/11 THROUGH 09/30/12  
 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	118,375.25	0.00	OTHER LAB	5,927.50	0.00
MED/SURG SUPPLY	384,532.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,297.75	3,592.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	112,948.25	3,564.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,240.00	FEE SCHEDULE LAB	172,694.40	48,392.94
EKG/ECG	17,041.25	1,111.25	MRI SERVICES	35,384.00	18,345.00
IV THERAPY	40,205.50	9,353.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	680,890.56	92,243.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,273.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	396,905.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,854.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	131,125.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52,727.00	13,661.75
RADIOLOGY THERAPEUTIC	644,167.00	4,416.25	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	570.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	767.50	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	114.50	171.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	60,601.25	6,196.25
LITHOTRIPSY	11,089.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,311.00	1,267.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,268.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	71,405.50	4,802.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,814.50	12,881.75			
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	27,693.00	0.00			
			TOTAL ANCILLARY	3,195,647.21	222,578.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,195,647.21	222,578.13

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 16:49:42  
Page: 15

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,471.00	ADJUSTMENTS	0.00
COVERED CHARGES	36,413.75	CONTRACTUAL ALLOW	14,492.15
NON-COVERD CHARGES	57.25	TOTAL MEDICAID LIAB	21,921.60
		LESS: COB	21,882.60
		LESS: COPAYMENT	39.00
		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: 09/24/2013  
 Run Time: 16:49:42  
 Page: 16

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CARTERSVILLE MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
960 JOE FRANK HARRIS PKWY SE	000001625A	SERVICE DATES	10/01/11	THROUGH	09/30/12
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	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	4,455.00	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	31,958.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	57.25	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	36,413.75	57.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,413.75	57.25

\*\* 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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,089,382.43	ADJUSTMENTS	29,577,715.38
COVERED CHARGES	133,949,058.05	CONTRACTUAL ALLOW	80,394,826.13
NON-COVERD CHARGES	5,140,324.38	TOTAL MEDICAID LIAB	53,554,231.92
		LESS: COB	185,771.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	53,368,460.83

TOTAL NUMBER OF ADMISSIONS 2,641

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,546		0	11,414,871.00		4,355,979.00
ROUTINE NURSERY	1,114		0	2,256,953.50		10,834.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,660		0	13,671,824.50		4,366,813.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	1,872		0	8,361,623.50		0.00
PED ICU	4,260		0	14,243,906.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,132		0	22,605,529.50		0.00
TOTAL ACCOMODATIONS	19,792		0	36,277,354.00		4,366,813.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER  
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,660,514.85	136,182.65	OTHER LAB	175,581.00	198.50
MED/SURG SUPPLY	7,132,156.67	92,688.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,315,600.99	46,821.05	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,881,206.50	4,104.50	OTHER THERAPEUTIC SVC	19,519.50	94,490.50
CT SCAN	1,672,797.00	38,175.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	583,412.50	3,486.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	41,921.50	0.00	MRI SERVICES	1,474,622.00	0.00
IV THERAPY	50,360.50	3,661.00	PROFESSIONAL FEES	0.00	16,646.50
OPERATING ROOM	8,018,022.53	24,923.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,247,386.90	127,140.51	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,286,728.50	3,972.00	AMBULANCE	0.00	0.00
GI SERVICES	28,585.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,336,724.60	72,493.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	894,231.50	520.50	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	590,465.50	1,454.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	83,412.50	3,640.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	240,738.50	3,480.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	280,570.00	614.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,242.00	PATIENT CONVENIENCE	0.00	42.75
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	600.00	25,981.00	TRAUMA RESPONSE	0.00	34,020.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,403,933.01	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	304,181.50	713.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	803,470.00	18,703.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	40,200.50	1,855.50			
AUDIOLOGY	29,824.00	0.00			
CARDIOLOGY	654,894.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,345,345.50	1,260.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,697.00	0.00			
			TOTAL ANCILLARY	97,671,704.05	773,511.38
			TOTAL ACCOMODATIONS	36,277,354.00	4,366,813.00
			TOTAL CHARGES	133,949,058.05	5,140,324.38



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 16:50:56  
 Page: 3

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,622,869.94	ADJUSTMENTS	0.00
COVERED CHARGES	2,546,503.44	CONTRACTUAL ALLOW	856,854.03
NON-COVERD CHARGES	76,366.50	TOTAL MEDICAID LIAB	1,689,649.41
		LESS: COB	1,689,649.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 63

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	239		0	221,025.00		50,861.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	239		0	221,025.00		50,861.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	2		0	8,867.00		0.00
PED ICU	32		0	109,593.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	34		0	118,460.00		0.00
TOTAL ACCOMODATIONS	273		0	339,485.00		50,861.00

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	448,194.50	0.00	OTHER LAB	3,005.00	0.00
MED/SURG SUPPLY	217,764.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	205,547.76	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,703.00	0.00	OTHER THERAPEUTIC SVC	142.00	1,537.50
CT SCAN	32,767.00	2,640.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,038.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	221.00	0.00	MRI SERVICES	31,922.00	0.00
IV THERAPY	1,317.00	0.00	PROFESSIONAL FEES	0.00	19,956.00
OPERATING ROOM	290,939.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	146,832.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,371.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,533.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,038.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	10,157.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	2,934.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,895.00	0.00	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	75.00	490.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	468,876.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,377.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	35,728.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,874.00	881.50			
AUDIOLOGY	245.00	0.00			
CARDIOLOGY	12,075.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,319.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,939.00	0.00			
			TOTAL ANCILLARY	2,207,018.44	25,505.50
			TOTAL ACCOMODATIONS	339,485.00	50,861.00
			TOTAL CHARGES	2,546,503.44	76,366.50

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: 09/24/2013  
Run Time: 16:51:02  
Page: 5

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,725,908.90	ADJUSTMENTS	3,501,478.23
COVERED CHARGES	39,732,350.56	CONTRACTUAL ALLOW	26,711,585.64
NON-COVERD CHARGES	1,993,558.34	TOTAL MEDICAID LIAB	13,020,764.92
		LESS: COB	163,639.79
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	12,856,858.13
		ALL OTHER	11,610,040.38
		FEE SCHEDULE-LAB	382,759.35
		INJECTABLE DRUGS	864,058.40

TOTAL NUMBER OF CLAIMS 21,427

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,775,691.75	30,591.75	OTHER LAB	173,239.50	0.00
MED/SURG SUPPLY	2,433,241.86	379.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	4,122.00	0.00
RADIOLOGY-DIAGNOSTIC	1,551,124.00	9,480.00	OTHER THERAPEUTIC SVC	139.00	3,148.50
CT SCAN	2,268,578.50	117,045.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	890,607.50	75,114.00	FEE SCHEDULE LAB	4,935,958.32	743,608.49
EKG/ECG	26,767.00	586.00	MRI SERVICES	3,143,858.00	151,922.50
IV THERAPY	823,513.00	5,735.00	PROFESSIONAL FEES	0.00	40,981.00
OPERATING ROOM	4,148,083.90	240,103.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	227,954.00	1,778.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,084,526.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	53,568.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,338,562.50	71,186.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	709,746.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,625,735.50	310,842.25
RADIOLOGY THERAPEUTIC	506,427.00	1,651.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	453,428.00	50,180.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	483,656.50	16,432.50	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	1,195,133.00	48,614.50	TRAUMA RESPONSE	0.00	23,207.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	228,112.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	572,235.00	1,549.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	536,957.00	6,195.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	224,629.00	33,060.50			
AUDIOLOGY	334,844.00	0.00			
CARDIOLOGY	66,977.50	875.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,518,362.50	7,700.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	396,571.23	1,589.00			
			TOTAL ANCILLARY	39,732,350.56	1,993,558.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,732,350.56	1,993,558.34

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5912240000269	06/01/12 - 06/01/12	09/03/12	0.00	0.00	0.00	0.00	0.00
932	2012304009507	07/09/12 - 07/09/12	11/05/12	0.00	0.00	0.00	137.50	0.00
TOTAL				0.00	0.00	0.00	137.50	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 16:54:33  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA  
1001 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1605

PROVIDER NUMBER  
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,625,183.50	ADJUSTMENTS	0.00
COVERED CHARGES	3,105,629.00	CONTRACTUAL ALLOW	1,043,871.04
NON-COVERD CHARGES	519,554.50	TOTAL MEDICAID LIAB	2,061,757.96
		LESS: COB	2,061,715.96
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,273

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 01/01/12 THROUGH 12/31/12  
 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	132,630.75	41,398.25	OTHER LAB	8,721.50	0.00
MED/SURG SUPPLY	338,314.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,135.50	471.50	OTHER THERAPEUTIC SVC	0.00	232.00
CT SCAN	112,939.50	32,331.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,868.50	4,373.50	FEE SCHEDULE LAB	422,649.50	51,438.00
EKG/ECG	1,326.00	0.00	MRI SERVICES	322,030.00	58,355.00
IV THERAPY	2,994.00	0.00	PROFESSIONAL FEES	0.00	128,550.50
OPERATING ROOM	357,441.00	119,304.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,023.00	931.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	234,918.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,338.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	315,151.50	6,879.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,309.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	126,683.00	25,079.75
RADIOLOGY THERAPEUTIC	101,445.50	11,320.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,900.00	2,490.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,717.50	8,607.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	51,199.00	953.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,875.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,686.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,688.50	21,644.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,886.00	2,675.00			
AUDIOLOGY	16,688.50	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	173,619.00	2,520.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,450.00	0.00			
			TOTAL ANCILLARY	3,105,629.00	519,554.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,105,629.00	519,554.50

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012215019717	06/01/12 - 06/01/12	08/06/12	0.00	0.00	0.00	2,982.60	0.00
932	2012215019717	06/04/12 - 06/04/12	08/06/12	0.00	0.00	0.00	2,982.60	0.00
932	2012215019717	06/05/12 - 06/05/12	08/06/12	0.00	0.00	0.00	2,982.60	0.00
932	2012215019717	06/06/12 - 06/06/12	08/06/12	0.00	0.00	0.00	2,982.60	0.00
932	2012293019903	08/23/12 - 08/23/12	10/22/12	0.00	0.00	0.00	504.90	0.00
TOTAL				0.00	0.00	0.00	12,435.30	0.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,043,646.75	ADJUSTMENTS	4,922.73
COVERED CHARGES	1,004,055.75	CONTRACTUAL ALLOW	938,016.27
NON-COVERD CHARGES	39,591.00	TOTAL MEDICAID LIAB	66,039.48
		LESS: COB	4,062.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	61,976.85
		TOTAL NUMBER OF CLAIMS	1,109

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,180.75	1,753.25	OTHER LAB	1,745.00	0.00
MED/SURG SUPPLY	31,591.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,429.50	518.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	56,444.00	3,249.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,228.50	899.50	FEE SCHEDULE LAB	146,975.00	20,912.25
EKG/ECG	1,989.00	0.00	MRI SERVICES	2,242.50	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	5,458.50
OPERATING ROOM	9,180.50	2,724.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,506.00	220.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	602,691.50	2,395.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,429.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,937.75	684.50
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	532.50	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	1,767.50	0.00	TRAUMA RESPONSE	0.00	776.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,262.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,656.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,768.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,887.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,311.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,600.00	0.00			
			TOTAL ANCILLARY	1,004,055.75	39,591.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,004,055.75	39,591.00

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

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,395.75	ADJUSTMENTS	0.00
COVERED CHARGES	54,664.25	CONTRACTUAL ALLOW	14,303.07
NON-COVERD CHARGES	21,731.50	TOTAL MEDICAID LIAB	40,361.18
		LESS: COB	40,361.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	50

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 16:54:55  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER  
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,780.50	45.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	764.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,594.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,624.50	2,690.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,554.50	1,263.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	15,853.50
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,723.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,179.50	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	585.75	590.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,078.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,278.50	1,289.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	440.00	0.00			
			TOTAL ANCILLARY	54,664.25	21,731.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,664.25	21,731.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,321,672.80	ADJUSTMENTS	603,842.80
COVERED CHARGES	7,054,614.80	CONTRACTUAL ALLOW	5,888,100.30
NON-COVERD CHARGES	267,058.00	TOTAL MEDICAID LIAB	1,166,514.50
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	1,166,445.50
		TOTAL NUMBER OF CLAIMS	170

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 1001 JOHNSON FERRY RD NE 000001636A SERVICE DATES 01/01/12 THROUGH 12/31/12  
 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	358,973.50	15,772.75	OTHER LAB	397.00	0.00
MED/SURG SUPPLY	832,613.66	171.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,332.50	3,383.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	54,198.50	14,763.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,630.50	5,554.00	FEE SCHEDULE LAB	50,122.50	7,284.50
EKG/ECG	221.00	221.00	MRI SERVICES	15,251.50	0.00
IV THERAPY	15,193.50	511.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,161,069.25	193,436.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,902.50	1,487.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	590,158.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,746.50	1,875.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	115,255.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	558,435.00	14,506.50
RADIOLOGY THERAPEUTIC	16,379.50	920.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	79,452.50	1,494.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,495.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,422.00	878.50	TRAUMA RESPONSE	0.00	1,553.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,899,260.14	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	820.00	891.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,365.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,382.00	881.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,515.50	875.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,626.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,395.75	598.00			
			TOTAL ANCILLARY	7,054,614.80	267,058.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,054,614.80	267,058.00

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: 09/24/2013  
Run Time: 16:55:07  
Page: 17

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	688,281.50	ADJUSTMENTS	0.00
COVERED CHARGES	673,996.50	CONTRACTUAL ALLOW	209,723.70
NON-COVERD CHARGES	14,285.00	TOTAL MEDICAID LIAB	464,272.80
		LESS: COB	464,272.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

SUMMARY TYPE VIII  
 ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER  
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,114.75	2,145.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	78,545.25	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	9,260.50	846.50
EKG/ECG	0.00	221.00	MRI SERVICES	0.00	2,450.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	97,212.50	6,711.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	195.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,530.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,914.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,397.00	505.25
RADIOLOGY THERAPEUTIC	821.50	520.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	125.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	401,789.50	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.	1,519.00	885.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	673,996.50	14,285.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	673,996.50	14,285.00



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 16:55:19  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	183,723.02	ADJUSTMENTS	0.00
COVERED CHARGES	180,759.52	CONTRACTUAL ALLOW	86,099.79
NON-COVERD CHARGES	2,963.50	TOTAL MEDICAID LIAB	94,659.73
		LESS: COB	1,547.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	93,112.60

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	47		0	35,203.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	47		0	35,203.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	47		0	35,203.00		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: 09/24/2013  
 Run Time: 16:55:19  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,266.75	0.00	OTHER LAB	496.50	0.00
MED/SURG SUPPLY	15,659.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,308.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,518.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,384.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,207.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,197.52	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,257.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,218.50	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	7,563.70	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	474.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,576.00	2,963.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,428.60	0.00			
			TOTAL ANCILLARY	145,556.52	2,963.50
			TOTAL ACCOMODATIONS	35,203.00	0.00
			TOTAL CHARGES	180,759.52	2,963.50

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,087,932.90	ADJUSTMENTS	17,769.27
COVERED CHARGES	927,724.72	CONTRACTUAL ALLOW	648,478.63
NON-COVERD CHARGES	160,208.18	TOTAL MEDICAID LIAB	279,246.09
		LESS: COB	0.00
		LESS: COPAYMENT	1,539.00
		REIMBURSEMENT	277,707.09
		ALL OTHER	248,288.95
		FEE SCHEDULE-LAB	29,418.14
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,082

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,392.65	1,514.85	OTHER LAB	3,946.50	0.00
MED/SURG SUPPLY	13,107.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,685.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	96,632.50	3,390.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,673.05	2,200.00	FEE SCHEDULE LAB	308,780.94	96,349.60
EKG/ECG	14,140.90	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	13,906.32	759.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	133,804.20	48,086.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,259.25	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	157,838.60	1,671.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	279.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	289.30	1,599.85	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	456.39	338.46	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,361.35	1,468.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	457.60	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	24,992.96	1,984.22			
			TOTAL ANCILLARY	927,724.72	160,208.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	927,724.72	160,208.18

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 16:55:42  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC  
215 MIMS RD  
SYLVANIA,GA 30467-1994

PROVIDER NUMBER  
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,198.80	ADJUSTMENTS	0.00
COVERED CHARGES	1,182.85	CONTRACTUAL ALLOW	817.63
NON-COVERD CHARGES	15.95	TOTAL MEDICAID LIAB	365.22
		LESS: COB	359.22
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 16:55:42  
 Page: 7

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 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	475.80	15.95
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	707.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,182.85	15.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,182.85	15.95

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 16:55:43  
Page: 8

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	120,129.20	ADJUSTMENTS	91.00
COVERED CHARGES	114,051.55	CONTRACTUAL ALLOW	104,301.55
NON-COVERD CHARGES	6,077.65	TOTAL MEDICAID LIAB	9,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	9,387.00
		TOTAL NUMBER OF CLAIMS	195



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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,915.25	150.35	OTHER LAB	731.16	0.00
MED/SURG SUPPLY	718.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,776.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,190.20	1,695.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,938.45	3,475.40
EKG/ECG	1,207.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,980.94	133.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	530.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,668.00	623.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,828.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	566.80	0.00			
			TOTAL ANCILLARY	114,051.55	6,077.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	114,051.55	6,077.65

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 16:55:46  
Page: 10

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	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 16:55:46  
Page: 11

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	355,895.90	ADJUSTMENTS	13,285.50
COVERED CHARGES	354,244.30	CONTRACTUAL ALLOW	247,888.30
NON-COVERD CHARGES	1,651.60	TOTAL MEDICAID LIAB	106,356.00
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	106,293.00

TOTAL NUMBER OF CLAIMS 24

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,615.71	17.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	258.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	302.50	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	7,183.63	388.85
EKG/ECG	517.35	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	301,495.46	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47.05	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,611.05	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	279.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	707.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,372.80	792.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,133.60	0.00			
			TOTAL ANCILLARY	354,244.30	1,651.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	354,244.30	1,651.60

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: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER 000001702A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,803,020.84	ADJUSTMENTS	32,665.40
COVERED CHARGES	2,713,472.55	CONTRACTUAL ALLOW	1,742,235.53
NON-COVERD CHARGES	89,548.29	TOTAL MEDICAID LIAB	971,237.02
		LESS: COB	5,658.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	965,578.91

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	483		0	384,919.92		9,524.45
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	483		0	384,919.92		9,524.45
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	64		0	128,250.56		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	128,250.56		0.00
TOTAL ACCOMODATIONS	547		0	513,170.48		9,524.45

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,271.00	0.00	OTHER LAB	15,216.35	0.00
MED/SURG SUPPLY	76,112.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	477,610.39	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,333.30	0.00	OTHER THERAPEUTIC SVC	0.00	1,208.72
CT SCAN	120,678.08	73,060.78	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,504.34	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	69,980.14	0.00	MRI SERVICES	45,872.48	0.00
IV THERAPY	37,036.93	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	109,233.88	2,377.95	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157,132.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,167.99	0.00	AMBULANCE	0.00	0.00
GI SERVICES	52,289.99	1,016.48	CAST ROOM	0.00	0.00
EMERGENCY ROOM	159,995.31	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,013.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	15,098.22	0.00	INJECTABLE DRUGS	432,314.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,270.49	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,391.80	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,684.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,901.06	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	463.00
OTHER IMAGING SERVICE	13,480.77	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,084.40	839.15			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	48,682.83	1,057.76			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,760.42	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,625.72	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,559.84	0.00			
			TOTAL ANCILLARY	2,200,302.07	80,023.84
			TOTAL ACCOMODATIONS	513,170.48	9,524.45
			TOTAL CHARGES	2,713,472.55	89,548.29

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: 09/24/2013  
Run Time: 16:55:54  
Page: 3

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212313014998	10/24/12 - 10/25/12	11/12/12	0.00	463.00	0.00	0.00	0.00
TOTAL				0.00	463.00	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: 09/24/2013  
Run Time: 16:55:59  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 16:55:59  
Page: 5

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,082,721.32	ADJUSTMENTS	6,680.52
COVERED CHARGES	3,797,846.68	CONTRACTUAL ALLOW	2,974,052.24
NON-COVERD CHARGES	284,874.64	TOTAL MEDICAID LIAB	823,794.44
		LESS: COB	849.99
		LESS: COPAYMENT	843.00
		REIMBURSEMENT	822,101.45
		ALL OTHER	768,280.71
		FEE SCHEDULE-LAB	52,942.93
		INJECTABLE DRUGS	877.81
		TOTAL NUMBER OF CLAIMS	1,690

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,666.33	4,856.89	OTHER LAB	32,286.80	0.00
MED/SURG SUPPLY	110,494.49	98.94	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	127.23	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	253,873.60	4,363.93	OTHER THERAPEUTIC SVC	0.00	7,904.52
CT SCAN	517,955.96	54,390.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,109.92	FEE SCHEDULE LAB	557,587.38	69,345.68
EKG/ECG	46,701.22	1,309.38	MRI SERVICES	89,437.64	12,170.04
IV THERAPY	160,682.86	21,142.37	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	157,877.33	37,428.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,578.74	3,659.34	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	97,547.13	622.58	AMBULANCE	0.00	0.00
GI SERVICES	106,343.72	6,970.69	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,086,170.15	2,350.07	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,909.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,656.57	1,483.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	413.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	154.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,195.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,344.00	0.00	IMPL DEV CHARGE PATIENTS	13,204.76	15,567.54
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	103,409.68	13,256.33			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,562.88	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	101,707.70	23,954.63			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,615.26	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	123,762.26	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,470.24	0.00			
			TOTAL ANCILLARY	3,797,846.68	284,874.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,797,846.68	284,874.64

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: 09/24/2013  
Run Time: 16:56:38  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	65,410.29	ADJUSTMENTS	0.00
COVERED CHARGES	54,164.54	CONTRACTUAL ALLOW	20,660.83
NON-COVERD CHARGES	11,245.75	TOTAL MEDICAID LIAB	33,503.71
		LESS: COB	33,494.71
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,582.68	276.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	507.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,592.79	345.58	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,814.00	3,137.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,431.46	850.92
EKG/ECG	1,091.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,883.01	51.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,030.04	4,794.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.24	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,448.14	311.29	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,215.77	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,006.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	356.03	87.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,344.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,651.76	1,391.44			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	54,164.54	11,245.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,164.54	11,245.75

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: 09/24/2013  
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EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	576,625.19	ADJUSTMENTS	52.94
COVERED CHARGES	545,878.01	CONTRACTUAL ALLOW	517,572.37
NON-COVERD CHARGES	30,747.18	TOTAL MEDICAID LIAB	28,305.64
		LESS: COB	0.00
		LESS: COPAYMENT	852.00
		REIMBURSEMENT	27,453.64
		TOTAL NUMBER OF CLAIMS	506

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	484.65	418.01	OTHER LAB	1,977.84	0.00
MED/SURG SUPPLY	2,348.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	108.36	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,966.66	428.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,725.55	1,814.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	283.05	FEE SCHEDULE LAB	86,358.57	10,199.45
EKG/ECG	4,801.06	0.00	MRI SERVICES	8,216.88	10,028.51
IV THERAPY	21,878.59	2,164.37	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,199.74	323.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	328,256.92	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	1,384.02	9.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,897.46	4,760.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,384.39	210.07			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,448.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	549.12	0.00			
			TOTAL ANCILLARY	545,878.01	30,747.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	545,878.01	30,747.18

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: 09/24/2013  
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EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,934.89	ADJUSTMENTS	0.00
COVERED CHARGES	3,913.94	CONTRACTUAL ALLOW	3,416.94
NON-COVERD CHARGES	20.95	TOTAL MEDICAID LIAB	497.00
		LESS: COB	494.00
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	838.72	20.95
EKG/ECG	218.23	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	383.71	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,420.82	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,913.94	20.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,913.94	20.95

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,186.30	ADJUSTMENTS	0.00
COVERED CHARGES	96,893.99	CONTRACTUAL ALLOW	76,241.87
NON-COVERD CHARGES	7,292.31	TOTAL MEDICAID LIAB	20,652.12
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	20,640.12
		TOTAL NUMBER OF CLAIMS	4

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,055.00	730.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,809.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	233.70
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,870.62	41.90
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,280.00	1,739.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	19,810.25	4,032.75
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68.64	514.80			
			TOTAL ANCILLARY	96,893.99	7,292.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,893.99	7,292.31

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER 000001713A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,787,207.02	ADJUSTMENTS	3,116,889.00
COVERED CHARGES	69,096,362.28	CONTRACTUAL ALLOW	56,819,922.16
NON-COVERD CHARGES	1,690,844.74	TOTAL MEDICAID LIAB	12,276,440.12
		LESS: COB	94,661.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,181,778.41
		TOTAL NUMBER OF ADMISSIONS	2,308

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,974		78	7,208,733.00		519,323.83
ROUTINE NURSERY	1,625		0	1,873,952.14		638,529.29
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		3,488.00
TOTAL ROUTINE	7,599		78	9,082,685.14		1,161,341.12
SPECIAL CARE SERVICES						
CCU	1,885		0	4,087,808.42		0.00
ICU	381		0	1,379,666.60		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,266		0	5,467,475.02		0.00
TOTAL ACCOMODATIONS	9,865		78	14,550,160.16		1,161,341.12

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,746,760.36	3,996.69	OTHER LAB	347,466.19	0.00
MED/SURG SUPPLY	5,204,076.52	90,425.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,729,346.95	2,800.28	EDUCATION & TRAINING	7,354.72	221.38
RADIOLOGY-DIAGNOSTIC	954,388.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,044,295.28	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	114,820.16	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	427,561.80	0.00	MRI SERVICES	748,046.24	0.00
IV THERAPY	65,388.00	521.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,557,355.58	14,144.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,348,713.34	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,762,491.03	4,472.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,773,530.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	163,564.20	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,910,628.38	51,336.38	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,287,659.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	319,371.60	0.00	INJECTABLE DRUGS	3,133.53	0.00
RADIOLOGY THERAPEUTIC	20,313.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	54,702.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	62,599.76	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	521,736.78	34,391.85	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	37,736.78	2,497.93	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	527,095.01	40,569.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	715,582.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	620,317.78	279,669.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	430,774.10	1,134.00			
AUDIOLOGY	159,218.85	0.00			
CARDIOLOGY	708,127.32	3,322.17			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,392.47	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	115,652.77	0.00			
			TOTAL ANCILLARY	54,546,202.12	529,503.62
			TOTAL ACCOMODATIONS	14,550,160.16	1,161,341.12
			TOTAL CHARGES	69,096,362.28	1,690,844.74

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:14:21  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER 000001713A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,651.23	ADJUSTMENTS	0.00
COVERED CHARGES	75,762.95	CONTRACTUAL ALLOW	43,639.43
NON-COVERD CHARGES	888.28	TOTAL MEDICAID LIAB	32,123.52
		LESS: COB	32,123.52
		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	12		0	14,820.00		888.28
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	14,820.00		888.28
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		0	14,820.00		888.28

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:14:21  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,367.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,068.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,989.11	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	360.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	178.24	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,255.51	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	6,998.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	556.31	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	168.19	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	60,942.95	0.00
			TOTAL ACCOMODATIONS	14,820.00	888.28
			TOTAL CHARGES	75,762.95	888.28



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 18:14:23  
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TENET HEALTHSYSTEM GB, INC  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,797,763.36	ADJUSTMENTS	1,046,313.42
COVERED CHARGES	23,296,836.64	CONTRACTUAL ALLOW	19,186,202.97
NON-COVERD CHARGES	2,500,926.72	TOTAL MEDICAID LIAB	4,110,633.67
		LESS: COB	6,654.07
		LESS: COPAYMENT	5,019.00
		REIMBURSEMENT	4,098,960.60
		ALL OTHER	3,883,068.01
		FEE SCHEDULE-LAB	173,615.31
		INJECTABLE DRUGS	42,277.28
		TOTAL NUMBER OF CLAIMS	6,322

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	764,812.40	28,342.99	OTHER LAB	226,515.13	1,810.16
MED/SURG SUPPLY	1,020,235.40	17,854.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	836.28	0.00
RADIOLOGY-DIAGNOSTIC	1,396,121.67	32,810.96	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,406,154.91	331,993.19	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,375.25	6,939.13	FEE SCHEDULE LAB	4,989,532.96	995,692.10
EKG/ECG	386,074.36	11,027.80	MRI SERVICES	739,222.75	39,268.71
IV THERAPY	496,604.23	39,400.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	701,176.99	184,129.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,377.98	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,489.27	22,882.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	751,751.22	2,515.59	AMBULANCE	0.00	0.00
GI SERVICES	536,933.58	36,944.48	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,844,275.79	47,008.81	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	148,970.55	2,090.88	DRUG-SPECIFIC/HOME IV	0.00	2,926.20
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	881,140.44	373,676.55
RADIOLOGY THERAPEUTIC	167,120.52	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	319.12	817.93	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,544.48	2,787.29	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,586.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,372.35	11,857.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	26,420.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,687,990.82	168,699.03			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,375.28	49,825.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	351,625.58	2,098.72			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	177,463.22	11,918.88			
AMBULATORY SURGERY	12,056.25	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	164,650.98	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	291,716.88	35,600.47			
			TOTAL ANCILLARY	23,296,836.64	2,500,926.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,296,836.64	2,500,926.72

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET HEALTHSYSTEM GB, INC  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,264.90	ADJUSTMENTS	0.00
COVERED CHARGES	93,063.17	CONTRACTUAL ALLOW	31,705.24
NON-COVERD CHARGES	17,201.73	TOTAL MEDICAID LIAB	61,357.93
		LESS: COB	61,357.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,483.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,063.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,419.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,160.10	8,326.74	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,079.20	6,732.53
EKG/ECG	3,238.64	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,661.74	168.19	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,128.63	1,323.69	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,529.99	650.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,214.03	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	1,084.20	0.00			
			TOTAL ANCILLARY	93,063.17	17,201.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,063.17	17,201.73

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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TENET HEALTHSYSTEM GB, INC  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,618,109.49	ADJUSTMENTS	2,165.58
COVERED CHARGES	1,497,600.93	CONTRACTUAL ALLOW	1,443,898.54
NON-COVERD CHARGES	120,508.56	TOTAL MEDICAID LIAB	53,702.39
		LESS: COB	0.00
		LESS: COPAYMENT	1,875.07
		REIMBURSEMENT	51,827.32
		TOTAL NUMBER OF CLAIMS	960

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,318.71	46.00	OTHER LAB	6,901.29	0.00
MED/SURG SUPPLY	20,745.39	1,429.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	85,048.25	917.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,697.03	26,530.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	325,970.13	63,542.48
EKG/ECG	18,529.96	1,065.88	MRI SERVICES	0.00	0.00
IV THERAPY	27,999.87	534.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	972.96	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,135.84	764.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,332.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,163.93	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	807,131.12	845.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,681.50	12,288.76
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	47,269.66	10,933.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,702.95	1,610.03			
			TOTAL ANCILLARY	1,497,600.93	120,508.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,497,600.93	120,508.56

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET HEALTHSYSTEM GB, INC  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,253.41	ADJUSTMENTS	0.00
COVERED CHARGES	4,253.41	CONTRACTUAL ALLOW	4,062.09
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	191.32
		LESS: COB	185.32
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	501.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	919.72	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	511.62	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,274.28	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,253.41	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,253.41	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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET HEALTHSYSTEM GB, INC  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,096,197.77	ADJUSTMENTS	224,187.72
COVERED CHARGES	3,449,198.17	CONTRACTUAL ALLOW	2,959,681.69
NON-COVERD CHARGES	646,999.60	TOTAL MEDICAID LIAB	489,516.48
		LESS: COB	0.00
		LESS: COPAYMENT	426.00
		REIMBURSEMENT	489,090.48

TOTAL NUMBER OF CLAIMS 96

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET HEALTHSYSTEM GB, INC  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,605.89	6,635.82	OTHER LAB	7,636.92	0.00
MED/SURG SUPPLY	540,316.59	11,096.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	774.83
RADIOLOGY-DIAGNOSTIC	59,829.38	21,490.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,416.00	14,205.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	780.55	FEE SCHEDULE LAB	318,647.20	43,283.64
EKG/ECG	28,799.32	3,874.08	MRI SERVICES	41,867.95	0.00
IV THERAPY	10,681.63	1,968.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,090,147.70	261,823.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	281.78	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,469.05	1,675.59	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	536,907.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,571.68	171.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	168,313.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,766.51
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	99,693.63	120,526.39
RADIOLOGY THERAPEUTIC	37,366.43	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	865.38	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	556.31	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,390.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	133,391.34
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,840.69	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,388.60	1,865.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	95,250.76	137.09			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,268.99	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,897.00	13,224.48			
			TOTAL ANCILLARY	3,449,198.17	646,503.66
			TOTAL ACCOMODATIONS	0.00	495.94
			TOTAL CHARGES	3,449,198.17	646,999.60

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TENET HEALTHSYSTEM GB, INC  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/11	THROUGH	05/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:16:44  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,925,044.73	ADJUSTMENTS	1,954,015.61
COVERED CHARGES	32,092,078.47	CONTRACTUAL ALLOW	19,370,425.48
NON-COVERD CHARGES	2,832,966.26	TOTAL MEDICAID LIAB	12,721,652.99
		LESS: COB	120,692.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,600,960.62

TOTAL NUMBER OF ADMISSIONS 1,816

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,786		0	4,424,362.00		2,260,018.75
ROUTINE NURSERY	503		0	273,530.00		32,210.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		74.25
TOTAL ROUTINE	8,289		0	4,697,892.00		2,292,303.00
SPECIAL CARE SERVICES						
CCU	170		0	243,100.00		0.00
ICU	1,054		0	1,451,780.00		0.00
NICU	26		0	33,800.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,250		0	1,728,680.00		0.00
TOTAL ACCOMODATIONS	9,539		0	6,426,572.00		2,292,303.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,626,011.89	80,150.35	OTHER LAB	88,013.50	0.00
MED/SURG SUPPLY	2,742,725.45	92,221.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,953,244.47	19,307.93	EDUCATION & TRAINING	24,257.25	4,607.25
RADIOLOGY-DIAGNOSTIC	357,151.95	155.00	OTHER THERAPEUTIC SVC	614.25	170.00
CT SCAN	1,134,107.94	6,472.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	126,739.25	7,753.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	268,099.00	292.50	MRI SERVICES	190,913.75	0.00
IV THERAPY	158,672.65	4,295.43	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,306,404.44	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	214,576.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,367,565.50	4,227.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	107,450.00	0.00	AMBULANCE	0.00	550.50
GI SERVICES	42,948.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	485,687.00	7,476.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	211,078.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	118,490.00	0.00	INJECTABLE DRUGS	2,809,433.31	1,991.75
RADIOLOGY THERAPEUTIC	68,993.75	790.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,958.25	3,858.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	42,559.11	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	260,084.50	21,820.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,730.00	1,759.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	402,995.00	10,883.25	IMPL DEV CHARGE PATIENTS	1,215,906.25	0.00
LITHOTRIPSY	24,939.00	0.00	NO CC/INVALID REV CODE	0.00	5,454.25
OTHER IMAGING SERVICE	151,247.50	55,950.00			
BLOOD	398,036.50	0.00			
BLOOD STORAGE & PRO.	75,520.25	185,377.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	66,324.75	8,355.50			
AUDIOLOGY	12,023.50	0.00			
CARDIOLOGY	739,783.00	0.00			
AMBULATORY SURGERY	234,774.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,003.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	563,443.50	16,741.75			
			TOTAL ANCILLARY	25,665,506.47	540,663.26
			TOTAL ACCOMODATIONS	6,426,572.00	2,292,303.00
			TOTAL CHARGES	32,092,078.47	2,832,966.26

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: 09/24/2013  
Run Time: 18:16:44  
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SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012233011913	04/11/12 - 04/13/12	08/27/12	0.00	1,760.50	0.00	0.00	0.00
615	2012233012499	02/24/12 - 02/27/12	08/27/12	0.00	1,760.50	0.00	0.00	0.00
905	2012275018465	09/14/12 - 09/24/12	10/08/12	0.00	172.75	0.00	0.00	0.00
615	5213212000155	04/25/12 - 06/06/12	08/05/13	0.00	1,760.50	0.00	0.00	0.00
TOTAL				0.00	5,454.25	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 09/24/2013  
 Run Time: 18:17:30  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	381,416.29	ADJUSTMENTS	0.00
COVERED CHARGES	362,050.04	CONTRACTUAL ALLOW	83,674.83
NON-COVERD CHARGES	19,366.25	TOTAL MEDICAID LIAB	278,375.21
		LESS: COB	278,375.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
TOTAL NUMBER OF ADMISSIONS			29

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	90		0	51,990.00		14,740.00
ROUTINE NURSERY	6		0	3,180.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	96		0	55,170.00		14,740.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,860.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	2,860.00		0.00
TOTAL ACCOMODATIONS	98		0	58,030.00		14,740.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,263.95	0.00	OTHER LAB	85.76	0.00
MED/SURG SUPPLY	36,412.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,512.50	0.00	EDUCATION & TRAINING	283.25	0.00
RADIOLOGY-DIAGNOSTIC	4,049.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,643.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	425.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,023.75	0.00	MRI SERVICES	2,170.75	0.00
IV THERAPY	172.00	0.00	PROFESSIONAL FEES	0.00	24.25
OPERATING ROOM	17,631.66	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,412.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,263.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,421.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,431.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,840.33	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,188.00	0.00	INJECTABLE DRUGS	49,053.01	0.00
RADIOLOGY THERAPEUTIC	6,096.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	161.55	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,299.75	0.00	IMPL DEV CHARGE PATIENTS	35,118.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,760.50
OTHER IMAGING SERVICE	1,358.50	0.00			
BLOOD	5,517.75	0.00			
BLOOD STORAGE & PRO.	210.00	2,841.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	86.50	0.00			
CARDIOLOGY	9,054.00	0.00			
AMBULATORY SURGERY	1,484.75	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,349.50	0.00			
			TOTAL ANCILLARY	304,020.04	4,626.25
			TOTAL ACCOMODATIONS	58,030.00	14,740.00
			TOTAL CHARGES	362,050.04	19,366.25



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: 09/24/2013  
Run Time: 18:17:30  
Page: 6

SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212251013973	06/17/12 - 06/18/12	09/10/12	0.00	1,760.50	0.00	5,144.59	0.00
TOTAL				0.00	1,760.50	0.00	5,144.59	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,903,514.95	ADJUSTMENTS	997,544.10
COVERED CHARGES	15,746,339.38	CONTRACTUAL ALLOW	10,599,894.99
NON-COVERD CHARGES	1,157,175.57	TOTAL MEDICAID LIAB	5,146,444.39
		LESS: COB	6,985.51
		LESS: COPAYMENT	12,918.29
		REIMBURSEMENT	5,126,540.59
		ALL OTHER	4,424,561.92
		FEE SCHEDULE-LAB	327,156.27
		INJECTABLE DRUGS	374,822.40
		TOTAL NUMBER OF CLAIMS	10,880

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,740,892.33	27,087.06	OTHER LAB	127,591.10	183.25
MED/SURG SUPPLY	1,159,270.17	930.58	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	285.50	EDUCATION & TRAINING	862.00	4,201.00
RADIOLOGY-DIAGNOSTIC	566,054.33	37,102.91	OTHER THERAPEUTIC SVC	0.00	110.75
CT SCAN	1,824,935.35	90,218.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	586.00	6,942.75	FEE SCHEDULE LAB	1,653,095.95	302,864.57
EKG/ECG	165,203.75	2,632.50	MRI SERVICES	331,914.25	25,202.00
IV THERAPY	494,257.64	44,355.81	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,256,364.21	239,114.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	89,151.25	10,787.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	219,299.75	842.75	AMBULANCE	0.00	0.00
GI SERVICES	126,813.53	16,771.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,136,745.14	3,350.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	405,765.35	505.95	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,974,129.82	82,011.70
RADIOLOGY THERAPEUTIC	346,274.00	12,744.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	444.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,651.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,293.81	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	97,544.75	8,478.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	78,670.00	3,691.50	IMPL DEV CHARGE PATIENTS	102,719.15	42,658.80
LITHOTRIPSY	12,469.50	0.00	NO CC/INVALID REV CODE	0.00	137.25
OTHER IMAGING SERVICE	509,394.38	46,130.00			
BLOOD	42,430.88	0.00			
BLOOD STORAGE & PRO.	7,235.62	45,170.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	147,961.75	1,425.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	348,793.00	46,421.75			
AMBULATORY SURGERY	268,799.00	23,501.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,635.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	452,479.68	22,926.48			
			TOTAL ANCILLARY	15,746,339.38	1,157,175.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,746,339.38	1,157,175.57

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
671	2212235013367	03/07/12 - 03/07/12	08/27/12	0.00	137.25	0.00	0.00	0.00
TOTAL				0.00	137.25	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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	98,355.75	ADJUSTMENTS	0.00
COVERED CHARGES	78,601.02	CONTRACTUAL ALLOW	21,487.19
NON-COVERD CHARGES	19,754.73	TOTAL MEDICAID LIAB	57,113.83
		LESS: COB	57,068.83
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 74

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,905.06	297.25	OTHER LAB	85.76	0.00
MED/SURG SUPPLY	5,488.75	17.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	153.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,231.31	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,520.75	7,095.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	72.75	FEE SCHEDULE LAB	14,258.39	2,620.25
EKG/ECG	1,316.25	0.00	MRI SERVICES	1,892.75	4,632.75
IV THERAPY	2,295.16	344.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,589.18	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	142.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,500.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,484.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,624.00	465.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,756.98	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,102.93	360.73
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	166.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,180.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,336.75	0.00			
BLOOD	770.50	0.00			
BLOOD STORAGE & PRO.	42.00	1,031.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,131.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,444.25	0.00			
			TOTAL ANCILLARY	78,601.02	19,754.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,601.02	19,754.73

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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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	768,083.60	ADJUSTMENTS	6,107.09
COVERED CHARGES	728,205.18	CONTRACTUAL ALLOW	659,510.86
NON-COVERD CHARGES	39,878.42	TOTAL MEDICAID LIAB	68,694.32
		LESS: COB	55.46
		LESS: COPAYMENT	2,061.15
		REIMBURSEMENT	66,577.71
		TOTAL NUMBER OF CLAIMS	1,228

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,298.24	130.73	OTHER LAB	7,389.50	404.25
MED/SURG SUPPLY	39,305.00	145.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	57.75
RADIOLOGY-DIAGNOSTIC	45,025.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,108.50	9,746.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	114,652.91	16,522.84
EKG/ECG	8,043.75	0.00	MRI SERVICES	6,123.00	0.00
IV THERAPY	44,912.29	2,804.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,904.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,100.25	443.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	416.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	292,100.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,127.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,712.24	4,102.95
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	83.00	230.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,184.00
OTHER IMAGING SERVICE	24,835.50	2,201.00			
BLOOD	1,337.00	0.00			
BLOOD STORAGE & PRO.	84.00	905.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,646.00	0.00			
			TOTAL ANCILLARY	728,205.18	39,878.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	728,205.18	39,878.42



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2011327033827	10/23/11 - 10/23/11	11/28/11	0.00	2,184.00	0.00	0.00	0.00
TOTAL				0.00	2,184.00	0.00	0.00	0.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,862.17	ADJUSTMENTS	0.00
COVERED CHARGES	5,789.17	CONTRACTUAL ALLOW	3,026.80
NON-COVERD CHARGES	73.00	TOTAL MEDICAID LIAB	2,762.37
		LESS: COB	2,762.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	92.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,039.42	73.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,724.25	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	2,804.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,789.17	73.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,789.17	73.00

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

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,381,819.57	ADJUSTMENTS	157,422.50
COVERED CHARGES	3,290,061.06	CONTRACTUAL ALLOW	2,626,685.72
NON-COVERD CHARGES	91,758.51	TOTAL MEDICAID LIAB	663,375.34
		LESS: COB	0.00
		LESS: COPAYMENT	1,512.00
		REIMBURSEMENT	661,863.34
		TOTAL NUMBER OF CLAIMS	131

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	382,405.11	78.25	OTHER LAB	829.00	0.00
MED/SURG SUPPLY	107,062.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,188.25	1,749.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,427.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	624.50	FEE SCHEDULE LAB	40,979.75	5,931.25
EKG/ECG	5,265.00	0.00	MRI SERVICES	4,672.50	0.00
IV THERAPY	169,917.75	946.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,056.25	3,285.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,325.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,414.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,930.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,976.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,877,303.00	37,957.51
RADIOLOGY THERAPEUTIC	262,351.00	420.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	152.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	72,773.50	0.00
LITHOTRIPSY	49,878.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,212.25	0.00			
BLOOD	881.00	0.00			
BLOOD STORAGE & PRO.	42.00	905.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,334.25	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	43,287.00	39,554.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	427.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,122.75	153.75			
			TOTAL ANCILLARY	3,290,061.06	91,758.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,290,061.06	91,758.51

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 18:20:21  
Page: 19

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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,898,626.93	ADJUSTMENTS	87,234.45
COVERED CHARGES	16,416,058.93	CONTRACTUAL ALLOW	10,952,162.87
NON-COVERD CHARGES	1,482,568.00	TOTAL MEDICAID LIAB	5,463,896.06
		LESS: COB	35,241.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,428,654.42

TOTAL NUMBER OF ADMISSIONS 804

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,183		0	3,057,970.00		1,373,440.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,183		0	3,057,970.00		1,373,440.00
SPECIAL CARE SERVICES						
CCU	310		0	413,400.00		0.00
ICU	299		0	397,500.00		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	609		0	810,900.00		0.00
TOTAL ACCOMODATIONS	5,792		0	3,868,870.00		1,373,440.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,362,031.18	0.00	OTHER LAB	53,555.25	0.00
MED/SURG SUPPLY	1,409,117.50	5,153.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,207,372.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200,539.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	321,423.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	132,527.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	119,660.75	0.00	MRI SERVICES	110,949.75	1,159.00
IV THERAPY	69,791.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	956,849.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	704,305.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	267,796.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	111,146.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	337,475.00	438.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	64,006.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	60,313.00
LABORATORY PATHOLOGIC	157,311.75	0.00	INJECTABLE DRUGS	15,320.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	49,129.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,747.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	75,195.75	25,587.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	538.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	975,072.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,237.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	114,271.75	2,097.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	41,212.00	11,785.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	585,356.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,746.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,042.20	2,056.00			
			TOTAL ANCILLARY	12,547,188.93	109,128.00
			TOTAL ACCOMODATIONS	3,868,870.00	1,373,440.00
			TOTAL CHARGES	16,416,058.93	1,482,568.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:20:52  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,483.98	ADJUSTMENTS	0.00
COVERED CHARGES	93,435.73	CONTRACTUAL ALLOW	22,412.28
NON-COVERD CHARGES	6,048.25	TOTAL MEDICAID LIAB	71,023.45
		LESS: COB	71,023.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	24		0	14,160.00		5,960.00
ROUTINE NURSERY	0		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	14,160.00		5,960.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	14,160.00		5,960.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,075.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,594.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,989.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,163.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,293.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	583.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,194.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,187.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,348.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,487.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,969.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,744.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	914.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	404.50	0.00	INJECTABLE DRUGS	200.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,794.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,332.50	88.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	79,275.73	88.25
			TOTAL ACCOMODATIONS	14,160.00	5,960.00
			TOTAL CHARGES	93,435.73	6,048.25

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: 09/24/2013  
Run Time: 18:20:53  
Page: 5

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,953,740.82	ADJUSTMENTS	205,038.93
COVERED CHARGES	5,387,415.87	CONTRACTUAL ALLOW	4,029,875.62
NON-COVERD CHARGES	566,324.95	TOTAL MEDICAID LIAB	1,357,540.25
		LESS: COB	5,261.60
		LESS: COPAYMENT	3,733.99
		REIMBURSEMENT	1,348,544.66
		ALL OTHER	1,258,808.20
		FEE SCHEDULE-LAB	88,248.38
		INJECTABLE DRUGS	1,488.08

TOTAL NUMBER OF CLAIMS 3,427

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	441,824.85	1,456.17
MED/SURG SUPPLY	394,538.75	507.25
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	235,491.25	4,303.00
CT SCAN	425,345.25	29,727.25
PHYSICAL THERAPY	60,726.50	22,699.25
EKG/ECG	114,583.75	874.50
IV THERAPY	57,831.00	4,500.75
OPERATING ROOM	618,652.86	150,946.54
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	66,315.75	10,995.75
ANESTHESIA	140,196.25	0.00
GI SERVICES	45,589.00	15,180.75
EMERGENCY ROOM	879,941.84	25,693.25
RECOVERY ROOM	65,356.25	476.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	594.50	0.00
OCCUPATIONAL THERAPY	10,883.75	4,721.50
SPEECH PATHOLOGY	778.50	2,211.75
RENAL DIALYSIS	0.00	648.25
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	38,353.75	646.00
PSYCHIATRIC SERVICES	40.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICE	73,983.50	2,208.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,460.00	1,572.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	48,918.50	19,933.75
AUDIOLOGY	0.00	0.00
CARDIOLOGY	537,070.75	69,984.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	51,483.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERV. RM	39,601.02	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
OTHER LAB	23,538.00	27.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SVC	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	785,338.69	162,971.51
MRI SERVICES	147,938.00	13,340.25
PROFESSIONAL FEES	0.00	0.00
DURABLE MED. EQUIP.	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,545.50
INJECTABLE DRUGS	6,550.61	16,344.48
HOME HEALTH SERVICES	0.00	21.50
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIFE	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
TRAUMA RESPONSE	0.00	0.00
IMPL DEV CHARGE PATIENTS	72,489.25	1,787.50
NO CC/INVALID REV CODE	0.00	0.00

TOTAL ANCILLARY	5,387,415.87	566,324.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,387,415.87	566,324.95

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE IV

Run Date: 09/24/2013  
 Run Time: 18:21:41  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,759.39	ADJUSTMENTS	0.00
COVERED CHARGES	93,662.40	CONTRACTUAL ALLOW	46,681.22
NON-COVERD CHARGES	46,096.99	TOTAL MEDICAID LIAB	46,981.18
		LESS: COB	46,888.18
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 73

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,553.40	169.91	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,089.25	36.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,184.25	246.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,616.25	6,380.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	295.25	FEE SCHEDULE LAB	9,958.00	1,415.00
EKG/ECG	583.00	0.00	MRI SERVICES	7,542.75	2,514.25
IV THERAPY	1,216.50	332.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,068.00	18,390.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	675.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,682.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,969.75	3,939.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,328.50	630.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,030.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,210.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	328.25	6.08
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	260.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	40.00	4,992.00	IMPL DEV CHARGE PATIENTS	4,595.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,317.00	160.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,431.25	378.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,046.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,145.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	93,662.40	46,096.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,662.40	46,096.99

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
 Run Time: 18:21:43  
 Page: 9

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	341,136.94	ADJUSTMENTS	535.40
COVERED CHARGES	325,466.69	CONTRACTUAL ALLOW	296,377.89
NON-COVERD CHARGES	15,670.25	TOTAL MEDICAID LIAB	29,088.80
		LESS: COB	0.00
		LESS: COPAYMENT	1,053.00
		REIMBURSEMENT	28,035.80

TOTAL NUMBER OF CLAIMS 520

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,952.19	0.00	OTHER LAB	27.00	0.00
MED/SURG SUPPLY	7,394.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,569.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,860.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67,526.75	12,841.75
EKG/ECG	4,518.25	0.00	MRI SERVICES	4,541.75	0.00
IV THERAPY	6,887.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	185.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,205.25	510.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	166,977.50	1,880.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	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	38.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	822.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	325,466.69	15,670.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	325,466.69	15,670.25





Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	362.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	64.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	301.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,053.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	404.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	67.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,472.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,726.19	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,726.19	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: 09/24/2013  
Run Time: 18:21:50  
Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,729,397.98	ADJUSTMENTS	83,573.56
COVERED CHARGES	1,610,864.05	CONTRACTUAL ALLOW	1,411,791.07
NON-COVERD CHARGES	118,533.93	TOTAL MEDICAID LIAB	199,072.98
		LESS: COB	7,570.82
		LESS: COPAYMENT	257.21
		REIMBURSEMENT	191,244.95
		TOTAL NUMBER OF CLAIMS	39

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	152,307.95	0.00	OTHER LAB	27.00	0.00
MED/SURG SUPPLY	121,960.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,928.25	3,130.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,596.00	1,053.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	920.50	FEE SCHEDULE LAB	24,131.69	7,549.56
EKG/ECG	3,352.25	583.00	MRI SERVICES	2,514.25	0.00
IV THERAPY	6,753.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	456,261.62	24,079.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	893.00	127.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,185.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,510.25	208.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,778.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	1,666.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,888.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	114.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	600,516.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	202.50	202.50			
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	169,834.87	77,011.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,110.17	0.00			
			TOTAL ANCILLARY	1,610,864.05	118,533.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,610,864.05	118,533.93

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 18:21:52  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,841,448.93	ADJUSTMENTS	22,442.30
COVERED CHARGES	4,773,885.05	CONTRACTUAL ALLOW	3,512,690.91
NON-COVERD CHARGES	67,563.88	TOTAL MEDICAID LIAB	1,261,194.14
		LESS: COB	19,609.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,241,584.58

TOTAL NUMBER OF ADMISSIONS 165

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	351		0	391,763.00		42,910.00
ROUTINE NURSERY	61		0	39,925.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	412		0	431,688.00		42,910.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	236		0	376,914.00		0.00
NICU	16		0	30,161.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	252		0	407,075.00		0.00
TOTAL ACCOMODATIONS	664		0	838,763.00		42,910.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	714,700.30	0.00	OTHER LAB	16,793.11	0.00
MED/SURG SUPPLY	510,369.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	262,066.37	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	122,904.39	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,691.42	1,684.19	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,610.43	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,124.59	0.00	MRI SERVICES	5,865.95	0.00
IV THERAPY	11,058.14	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	656,344.14	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	164,665.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	96,938.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	225,405.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	33,237.14	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	191,857.64	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	126,116.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	21,728.53	0.00	INJECTABLE DRUGS	7,301.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,727.69	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,002.29	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	20,133.52	18,742.48	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	398,858.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,697.12	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	44,652.72	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,809.08	4,227.21			
AUDIOLOGY	13,635.03	0.00			
CARDIOLOGY	144,799.11	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	17,029.03	0.00			
			TOTAL ANCILLARY	3,935,122.05	24,653.88
			TOTAL ACCOMODATIONS	838,763.00	42,910.00
			TOTAL CHARGES	4,773,885.05	67,563.88

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,364.37	ADJUSTMENTS	0.00
COVERED CHARGES	49,846.37	CONTRACTUAL ALLOW	38,561.03
NON-COVERD CHARGES	518.00	TOTAL MEDICAID LIAB	11,285.34
		LESS: COB	11,285.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6		0	7,076.00		518.00
ROUTINE NURSERY	3		0	1,929.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	9,005.00		518.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	9,005.00		518.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA  
 2260 WRIGHTSBORO RD  
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,172.68	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,683.97	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	248.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,990.23	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,520.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,274.96	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	674.24	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,607.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	899.89	0.00	INJECTABLE DRUGS	308.02	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	461.58	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	40,841.37	0.00
			TOTAL ACCOMODATIONS	9,005.00	518.00
			TOTAL CHARGES	49,846.37	518.00

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: 09/24/2013  
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Page: 5

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,031,949.72	ADJUSTMENTS	509,850.24
COVERED CHARGES	4,728,796.55	CONTRACTUAL ALLOW	3,714,110.61
NON-COVERD CHARGES	303,153.17	TOTAL MEDICAID LIAB	1,014,685.94
		LESS: COB	8,131.54
		LESS: COPAYMENT	2,265.00
		REIMBURSEMENT	1,004,289.40
		ALL OTHER	945,278.45
		FEE SCHEDULE-LAB	53,814.01
		INJECTABLE DRUGS	5,196.94
		TOTAL NUMBER OF CLAIMS	1,971

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,740.10	35.68	OTHER LAB	157,398.22	0.00
MED/SURG SUPPLY	108,260.71	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	220.65	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,135.40	9,083.72	OTHER THERAPEUTIC SVC	134,951.86	1,509.42
CT SCAN	143,468.75	27,000.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,943.81	3,068.17	FEE SCHEDULE LAB	355,020.45	44,673.58
EKG/ECG	36,118.80	204.53	MRI SERVICES	33,030.71	0.00
IV THERAPY	209,118.10	17,407.93	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	578,698.91	96,337.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,546.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,467.09	138.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	457,902.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	312,038.97	41,941.78	CAST ROOM	0.00	0.00
EMERGENCY ROOM	836,111.61	11,872.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	366,259.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	106,261.69	6,989.70
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	841.18	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,351.31	727.45	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	110,524.65	0.00
LITHOTRIPSY	12,966.25	0.00	NO CC/INVALID REV CODE	0.00	21.75
OTHER IMAGING SERVICE	95,644.47	2,061.38			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,024.82	1,842.51			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,567.21	364.93			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	184,967.29	36,600.06			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	173,277.61	210.00			
			TOTAL ANCILLARY	4,728,796.55	303,153.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,728,796.55	303,153.17

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5212321005542	01/03/12 - 01/03/12	01/14/13	0.00	21.75	0.00	92.00	0.00
TOTAL				0.00	21.75	0.00	92.00	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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TRINITY HOSPITAL OF AUGUSTA  
2260 WRIGHTSBORO RD  
AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,871.40	ADJUSTMENTS	0.00
COVERED CHARGES	58,227.01	CONTRACTUAL ALLOW	35,483.22
NON-COVERD CHARGES	5,644.39	TOTAL MEDICAID LIAB	22,743.79
		LESS: COB	22,722.79
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 40

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,344.35	149.94	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,707.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,837.74	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,320.18	487.65
EKG/ECG	378.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,071.24	630.97	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,720.59	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	375.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	432.24	138.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,260.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,354.82	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,552.73	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,419.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,508.50	3,342.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	261.84	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	625.02	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,676.60	894.42			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,188.26	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,192.17	0.00			
			TOTAL ANCILLARY	58,227.01	5,644.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,227.01	5,644.39

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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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	211,027.79	ADJUSTMENTS	1,397.44
COVERED CHARGES	205,942.65	CONTRACTUAL ALLOW	191,677.95
NON-COVERD CHARGES	5,085.14	TOTAL MEDICAID LIAB	14,264.70
		LESS: COB	0.00
		LESS: COPAYMENT	498.00
		REIMBURSEMENT	13,766.70
		TOTAL NUMBER OF CLAIMS	255

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,435.69	6.40	OTHER LAB	868.49	0.00
MED/SURG SUPPLY	768.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,186.05	248.42	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,790.46	1,844.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,873.56	2,133.21
EKG/ECG	1,181.54	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,495.16	845.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,288.41	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	156,406.26	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	1,512.98	7.81
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	625.02	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,511.00	0.00			
			TOTAL ANCILLARY	205,942.65	5,085.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	205,942.65	5,085.14



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 18:22:41  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,441.32	ADJUSTMENTS	0.00
COVERED CHARGES	6,115.82	CONTRACTUAL ALLOW	5,529.97
NON-COVERD CHARGES	325.50	TOTAL MEDICAID LIAB	585.85
		LESS: COB	579.85
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TRINITY HOSPITAL OF AUGUSTA  
 2260 WRIGHTSBORO RD  
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	234.36	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	895.23	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	657.22	325.50
EKG/ECG	189.35	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,050.21	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,115.82	325.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,115.82	325.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TRINITY HOSPITAL OF AUGUSTA  
2260 WRIGHTSBORO RD  
AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	668,277.88	ADJUSTMENTS	87,782.34
COVERED CHARGES	661,596.98	CONTRACTUAL ALLOW	573,706.64
NON-COVERD CHARGES	6,680.90	TOTAL MEDICAID LIAB	87,890.34
		LESS: COB	0.00
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	87,782.34
		TOTAL NUMBER OF CLAIMS	17

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,413.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42,480.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,860.07	1,809.46	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,372.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,105.95	1,199.18
EKG/ECG	1,782.87	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	396.21	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	164,678.66	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58,679.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,044.18	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,050.31	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,486.41	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,084.17	300.18
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	129,240.89	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	250.33	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,278.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	103,244.04	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,520.97	0.00			
			TOTAL ANCILLARY	661,596.98	6,680.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	661,596.98	6,680.90

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: 09/24/2013  
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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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH  
 11705 MERCY BLVD  
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER 000001801A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,271,480.92	ADJUSTMENTS	1,007,672.74
COVERED CHARGES	31,878,926.72	CONTRACTUAL ALLOW	23,785,294.81
NON-COVERD CHARGES	392,554.20	TOTAL MEDICAID LIAB	8,093,631.91
		LESS: COB	181,228.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,912,403.13

TOTAL NUMBER OF ADMISSIONS 559

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,786		0	1,542,131.00		2,595.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,786		0	1,542,131.00		2,595.00
SPECIAL CARE SERVICES						
CCU	410		0	1,197,578.00		0.00
ICU	2,321		0	4,072,109.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,731		0	5,269,687.00		0.00
TOTAL ACCOMODATIONS	4,517		0	6,811,818.00		2,595.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:22:49  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,994,921.00	476.00	OTHER LAB	143,776.00	0.00
MED/SURG SUPPLY	1,890,108.45	45,015.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,628,301.77	10,984.23	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,092,403.00	353.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	828,117.00	55,326.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	348,879.00	993.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	84,766.00	0.00	MRI SERVICES	340,932.00	0.00
IV THERAPY	115,383.00	4,342.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,903,442.00	13,634.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,007,479.00	2.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	597,470.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	128,712.00	1,384.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	334,078.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	313,344.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	116,737.00	0.00	INJECTABLE DRUGS	3,277,626.00	287.00
RADIOLOGY THERAPEUTIC	47,358.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	170,765.00	769.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	152,333.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	308,951.00	40,500.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	302.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,205,329.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	152,620.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	881,628.00	160,366.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	98,093.00	55,527.00			
AUDIOLOGY	6,791.00	0.00			
CARDIOLOGY	719,098.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,773.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,592.00	0.00			
			TOTAL ANCILLARY	25,067,108.72	389,959.20
			TOTAL ACCOMODATIONS	6,811,818.00	2,595.00
			TOTAL CHARGES	31,878,926.72	392,554.20

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:23:06  
 Page: 3

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	672,457.00	ADJUSTMENTS	0.00
COVERED CHARGES	672,457.00	CONTRACTUAL ALLOW	553,238.90
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	119,218.10
		LESS: COB	119,218.10
		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	2		0	1,730.00		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	1,730.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	91		0	140,217.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	91		0	140,217.00		0.00
TOTAL ACCOMODATIONS	93		0	141,947.00		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: 09/24/2013  
 Run Time: 18:23:06  
 Page: 4

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,311.00	0.00	OTHER LAB	451.00	0.00
MED/SURG SUPPLY	9,653.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,361.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,340.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,280.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,481.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	504.00	0.00	MRI SERVICES	6,660.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	40,897.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,582.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,767.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,334.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,054.00	0.00	INJECTABLE DRUGS	199,893.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,652.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,436.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,216.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,571.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,260.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	963.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	530,510.00	0.00
			TOTAL ACCOMODATIONS	141,947.00	0.00
			TOTAL CHARGES	672,457.00	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 18:23:06  
Page: 5

ST JOSEPH'S HOSPITAL SAVANNAH  
11705 MERCY BLVD  
SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,501,661.90	ADJUSTMENTS	304,636.39
COVERED CHARGES	5,131,726.58	CONTRACTUAL ALLOW	4,045,678.83
NON-COVERD CHARGES	369,935.32	TOTAL MEDICAID LIAB	1,086,047.75
		LESS: COB	9,059.84
		LESS: COPAYMENT	1,593.00
		REIMBURSEMENT	1,075,394.91
		ALL OTHER	976,115.38
		FEE SCHEDULE-LAB	92,593.33
		INJECTABLE DRUGS	6,686.20
		TOTAL NUMBER OF CLAIMS	1,979

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232,983.00	45,782.00	OTHER LAB	47,624.00	859.00
MED/SURG SUPPLY	206,537.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	411,925.00	27,843.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	643,486.00	34,191.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,068.00	15,066.00	FEE SCHEDULE LAB	574,594.20	87,160.70
EKG/ECG	49,503.00	1,008.00	MRI SERVICES	81,957.00	7,509.00
IV THERAPY	194,862.00	11,095.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	457,079.88	41,909.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,106.00	1,452.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	111,457.00	359.00	AMBULANCE	0.00	0.00
GI SERVICES	16,608.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	748,205.00	260.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	296,091.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	133,690.00	17,730.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,438.00	2,836.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,257.00	1,259.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	6,000.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,510.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	121,422.00	6,564.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	72,204.00	7,326.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,362.00	4,000.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	59,010.00	2,258.00			
AUDIOLOGY	150,190.00	24,640.00			
CARDIOLOGY	394,572.50	14,299.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,299.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,196.00	7,019.00			
			TOTAL ANCILLARY	5,131,726.58	369,935.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,131,726.58	369,935.32

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 18:23:48  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	147,734.00	ADJUSTMENTS	0.00
COVERED CHARGES	90,810.00	CONTRACTUAL ALLOW	34,110.00
NON-COVERD CHARGES	56,924.00	TOTAL MEDICAID LIAB	56,700.00
		LESS: COB	56,659.88
		LESS: COPAYMENT	40.12
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,141.00	914.00	OTHER LAB	1,524.00	610.00
MED/SURG SUPPLY	6,878.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,369.00	776.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,971.00	4,167.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,029.00	694.00
EKG/ECG	1,134.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,343.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	888.00	26,364.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,456.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,657.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,147.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,211.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,144.00	2,592.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,424.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	758.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	6,002.00	5,986.00			
CARDIOLOGY	0.00	14,821.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,734.00	0.00			
			TOTAL ANCILLARY	90,810.00	56,924.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,810.00	56,924.00

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	280,141.00	ADJUSTMENTS	1,503.28
COVERED CHARGES	268,712.00	CONTRACTUAL ALLOW	256,013.64
NON-COVERD CHARGES	11,429.00	TOTAL MEDICAID LIAB	12,698.36
		LESS: COB	0.00
		LESS: COPAYMENT	471.05
		REIMBURSEMENT	12,227.31
		TOTAL NUMBER OF CLAIMS	227

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,198.00	2,128.00	OTHER LAB	3,887.00	0.00
MED/SURG SUPPLY	9,008.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,368.00	831.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,699.00	3,677.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	411.00	0.00	FEE SCHEDULE LAB	43,123.00	2,252.00
EKG/ECG	1,764.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,014.00	1,628.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,001.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	924.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,356.00	185.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	126,012.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,964.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,132.00	312.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,947.00	416.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	904.00	0.00			
			TOTAL ANCILLARY	268,712.00	11,429.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	268,712.00	11,429.00

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,535.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,478.00	CONTRACTUAL ALLOW	7,770.61
NON-COVERD CHARGES	1,057.00	TOTAL MEDICAID LIAB	2,707.39
		LESS: COB	2,680.38
		LESS: COPAYMENT	27.01

REIMBURSEMENT 0.00

TOTAL NUMBER OF CLAIMS 11



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110.00	119.00	OTHER LAB	451.00	408.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	827.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,325.00	530.00
EKG/ECG	252.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,651.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,290.00	0.00	SPECIAL SERVICES	0.00	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	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,478.00	1,057.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,478.00	1,057.00

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: 09/24/2013  
Run Time: 18:23:55  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,906,156.05	ADJUSTMENTS	81,533.95
COVERED CHARGES	1,771,388.93	CONTRACTUAL ALLOW	1,569,882.52
NON-COVERD CHARGES	134,767.12	TOTAL MEDICAID LIAB	201,506.41
		LESS: COB	0.00
		LESS: COPAYMENT	169.75
		REIMBURSEMENT	201,336.66

TOTAL NUMBER OF CLAIMS 37

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,210.00	11,216.00	OTHER LAB	5,646.00	1,158.00
MED/SURG SUPPLY	175,200.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,873.00	22,115.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,336.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,241.00	3,095.80
EKG/ECG	1,764.00	630.00	MRI SERVICES	0.00	0.00
IV THERAPY	179.00	179.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	188,643.00	38,422.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	940.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,488.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,194.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	160,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,714.00	3,068.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	550.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	885,980.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,922.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,454.00	1,414.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,129.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	148,815.68	50,452.32			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	731.00	731.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,529.00	1,736.00			
			TOTAL ANCILLARY	1,771,388.93	134,767.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,771,388.93	134,767.12

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:24:03  
 Page: 1

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 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,525,978.15	ADJUSTMENTS	36,681.75
COVERED CHARGES	10,216,725.90	CONTRACTUAL ALLOW	7,454,010.28
NON-COVERD CHARGES	309,252.25	TOTAL MEDICAID LIAB	2,762,715.62
		LESS: COB	154,227.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,608,488.47

TOTAL NUMBER OF ADMISSIONS 225

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,317		27	1,418,506.25		75,093.25
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	1,317		27	1,418,506.25		75,093.25
SPECIAL CARE SERVICES						
CCU	152		0	442,875.25		0.00
ICU	142		9	450,502.50		30,899.25
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	294		9	893,377.75		30,899.25
TOTAL ACCOMODATIONS	1,611		36	2,311,884.00		105,992.50

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:24:03  
 Page: 2

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 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,283,949.86	1,580.75	OTHER LAB	62,542.50	0.00
MED/SURG SUPPLY	565,996.25	78,373.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	870,571.50	190.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	271,708.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	540,001.00	6,006.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,459.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	37,995.50	0.00	MRI SERVICES	98,244.75	0.00
IV THERAPY	53,424.50	0.00	PROFESSIONAL FEES	0.00	957.25
OPERATING ROOM	862,578.00	807.00	DURABLE MED. EQUIP.	0.00	398.75
LABOR/DELIVERY ROOM	267.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	497,743.00	165.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	87,969.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,006.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	156,143.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	90,770.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,500.00
LABORATORY PATHOLOGIC	52,702.25	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	27,498.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,192.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,588.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	108,408.75	21,836.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	627.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,895.00	0.00	IMPL DEV CHARGE PATIENTS	466,457.29	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,709.00	51,164.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	161,528.75	34,653.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	48,232.75	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	378,346.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,448.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,463.50	0.00			
			TOTAL ANCILLARY	7,904,841.90	203,259.75
			TOTAL ACCOMODATIONS	2,311,884.00	105,992.50
			TOTAL CHARGES	10,216,725.90	309,252.25

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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 01/01/12 THROUGH 08/31/12  
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: 09/24/2013  
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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 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,236,228.74	ADJUSTMENTS	101,417.32
COVERED CHARGES	2,388,392.10	CONTRACTUAL ALLOW	1,874,102.29
NON-COVERD CHARGES	847,836.64	TOTAL MEDICAID LIAB	514,289.81
		LESS: COB	14,304.48
		LESS: COPAYMENT	1,243.86
		REIMBURSEMENT	498,741.47
		ALL OTHER	452,944.74
		FEE SCHEDULE-LAB	27,171.99
		INJECTABLE DRUGS	18,624.74

TOTAL NUMBER OF CLAIMS 781



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 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,322.70	867.50	OTHER LAB	25,588.50	0.00
MED/SURG SUPPLY	39,916.75	10,694.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	158,461.00	4,889.00	OTHER THERAPEUTIC SVC	332.25	327.00
CT SCAN	296,152.00	14,664.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,603.75	110.00	FEE SCHEDULE LAB	222,477.25	41,494.68
EKG/ECG	21,163.75	1,328.75	MRI SERVICES	82,997.00	2,816.25
IV THERAPY	70,766.50	8,461.00	PROFESSIONAL FEES	0.00	63.00
OPERATING ROOM	195,096.99	63,324.26	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,032.75	93.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,720.25	2,836.75	AMBULANCE	0.00	0.00
GI SERVICES	16,022.50	3,503.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	300,610.50	4,935.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	69,018.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	120,930.95	58,913.70
RADIOLOGY THERAPEUTIC	248,573.25	305,725.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,720.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,734.00	454.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,165.21	164,587.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	79,127.25	9,831.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,298.75	2,903.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	65,061.75	12,120.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	119,428.50	127,031.75			
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	49,790.00	140.25			
			TOTAL ANCILLARY	2,388,392.10	847,836.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,388,392.10	847,836.64

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,001.75	ADJUSTMENTS	0.00
COVERED CHARGES	12,169.25	CONTRACTUAL ALLOW	7,785.51
NON-COVERD CHARGES	5,832.50	TOTAL MEDICAID LIAB	4,383.74
		LESS: COB	4,368.74
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	167.75	0.00	OTHER LAB	357.00	0.00
MED/SURG SUPPLY	341.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,420.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,423.50	83.25
EKG/ECG	0.00	0.00	MRI SERVICES	3,710.75	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,116.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	533.25	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,665.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	90.00	618.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,877.25	177.50			
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	0.00	0.00			
			TOTAL ANCILLARY	12,169.25	5,832.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,169.25	5,832.50

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

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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 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,716.45	ADJUSTMENTS	108.88
COVERED CHARGES	48,809.45	CONTRACTUAL ALLOW	46,124.33
NON-COVERD CHARGES	907.00	TOTAL MEDICAID LIAB	2,685.12
		LESS: COB	0.00
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	2,562.12
		TOTAL NUMBER OF CLAIMS	48

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,478.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	257.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,171.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,794.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,705.25	896.00
EKG/ECG	667.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	992.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,053.50	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	468.65	11.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,221.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	48,809.45	907.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,809.45	907.00

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: 09/24/2013  
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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 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,727.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,512.25	CONTRACTUAL ALLOW	559.25
NON-COVERD CHARGES	2,215.50	TOTAL MEDICAID LIAB	953.00
		LESS: COB	950.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,210.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	440.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	281.25	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	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	138.25	5.25
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
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,512.25	2,215.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,512.25	2,215.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	790,674.01	ADJUSTMENTS	11,372.12
COVERED CHARGES	579,557.39	CONTRACTUAL ALLOW	516,928.23
NON-COVERD CHARGES	211,116.62	TOTAL MEDICAID LIAB	62,629.16
		LESS: COB	0.00
		LESS: COPAYMENT	87.00
		REIMBURSEMENT	62,542.16
		TOTAL NUMBER OF CLAIMS	11



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 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,761.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	45,555.50	1,786.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,310.25	963.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,341.63	2,234.80
EKG/ECG	667.50	267.00	MRI SERVICES	2,891.75	0.00
IV THERAPY	2,635.75	0.00	PROFESSIONAL FEES	0.00	21.00
OPERATING ROOM	115,864.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	554.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,506.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,167.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,779.50	4,482.25
RADIOLOGY THERAPEUTIC	55,409.50	40,079.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	157.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	257,248.76	160,547.82
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	461.00	734.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,245.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	579,557.39	211,116.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	579,557.39	211,116.62

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: 09/24/2013  
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Page: 14

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	01/01/12	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:24:19  
 Page: 1

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,443,688.17	ADJUSTMENTS	364,326.37
COVERED CHARGES	12,422,019.29	CONTRACTUAL ALLOW	8,126,398.65
NON-COVERD CHARGES	1,021,668.88	TOTAL MEDICAID LIAB	4,295,620.64
		LESS: COB	45,525.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,250,095.51

TOTAL NUMBER OF ADMISSIONS 480

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,111		0	858,623.00		212,772.00
ROUTINE NURSERY	164		0	133,566.00		264.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,275		0	992,189.00		213,036.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	753		0	1,322,406.00		0.00
NICU	2		0	3,852.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	4		0	6,552.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		246	0.00		232,398.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	759		246	1,332,810.00		232,398.00
TOTAL ACCOMODATIONS	2,034		246	2,324,999.00		445,434.00

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,643,139.79	24,379.06	OTHER LAB	138,183.00	1,183.00
MED/SURG SUPPLY	667,707.95	12,790.82	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	766,846.54	4,355.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	336,868.00	1,446.00	OTHER THERAPEUTIC SVC	0.00	152.00
CT SCAN	0.00	456,563.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	156,586.00	546.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	72,675.00	0.00	MRI SERVICES	269,761.00	10,110.00
IV THERAPY	187,780.76	301.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,110,468.00	8,793.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	153,107.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	652,115.00	1,840.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	290,380.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	60,924.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	460,697.00	1,538.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	198,276.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	52,130.00	0.00	INJECTABLE DRUGS	1,192.71	0.00
RADIOLOGY THERAPEUTIC	5,566.54	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	113,732.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	96,842.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	166,208.00	30,528.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	348.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	934.00	0.00	IMPL DEV CHARGE PATIENTS	734,466.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,064.00
OTHER IMAGING SERVICE	100,627.00	1,009.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	124,517.00	4,017.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,867.00	6,617.00			
AUDIOLOGY	5,247.00	2,003.00			
CARDIOLOGY	456,664.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	39,084.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,080.00	0.00			
			TOTAL ANCILLARY	10,097,020.29	576,234.88
			TOTAL ACCOMODATIONS	2,324,999.00	445,434.00
			TOTAL CHARGES	12,422,019.29	1,021,668.88

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: 09/24/2013  
Run Time: 18:24:19  
Page: 3

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012292078496	04/08/12 - 04/11/12	10/22/12	0.00	4,200.00	0.00	0.00	0.00
780	2012292078497	06/24/12 - 06/26/12	10/22/12	0.00	1,680.00	0.00	0.00	0.00
780	2012325064822	07/21/12 - 07/24/12	11/26/12	0.00	2,184.00	0.00	0.00	0.00
TOTAL				0.00	8,064.00	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: 09/24/2013  
 Run Time: 18:24:28  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,598.59	ADJUSTMENTS	0.00
COVERED CHARGES	134,744.59	CONTRACTUAL ALLOW	54,246.68
NON-COVERD CHARGES	854.00	TOTAL MEDICAID LIAB	80,497.91
		LESS: COB	80,497.91
		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	4,924.00		854.00
ROUTINE NURSERY	0		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	4,924.00		854.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	4,924.00		854.00

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,880.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,215.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,750.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,812.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	653.00	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	11,040.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,729.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,950.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,146.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	78.00	0.00	INJECTABLE DRUGS	1,527.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	376.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	87,662.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	129,820.59	0.00
			TOTAL ACCOMODATIONS	4,924.00	854.00
			TOTAL CHARGES	134,744.59	854.00

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: 09/24/2013  
Run Time: 18:24:29  
Page: 6

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,005,079.89	ADJUSTMENTS	444,746.64
COVERED CHARGES	9,125,802.30	CONTRACTUAL ALLOW	7,043,342.66
NON-COVERD CHARGES	879,277.59	TOTAL MEDICAID LIAB	2,082,459.64
		LESS: COB	51,196.62
		LESS: COPAYMENT	4,297.30
		REIMBURSEMENT	2,026,965.72
		ALL OTHER	1,793,547.80
		FEE SCHEDULE-LAB	157,546.93
		INJECTABLE DRUGS	75,870.99

TOTAL NUMBER OF CLAIMS 4,762



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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	216,312.97	453.44	OTHER LAB	80,105.00	0.00
MED/SURG SUPPLY	258,636.00	64,702.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	97.00	EDUCATION & TRAINING	798.00	0.00
RADIOLOGY-DIAGNOSTIC	576,824.00	17,415.00	OTHER THERAPEUTIC SVC	0.00	9,662.00
CT SCAN	692,756.00	25,553.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	39,249.00	9,568.00	FEE SCHEDULE LAB	711,856.06	81,330.50
EKG/ECG	118,527.80	4,803.00	MRI SERVICES	311,489.00	12,922.00
IV THERAPY	662,848.28	78,687.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	956,315.50	136,925.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,360.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	93,116.00	8,835.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	344,540.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	53,716.00	8,653.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,605,416.00	26,039.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	448,794.00	1,521.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	588,670.19	179,293.15
RADIOLOGY THERAPEUTIC	4,524.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,437.00	3,393.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,833.50	7,996.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,696.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90,200.00	3,949.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	22,176.00	0.00	IMPL DEV CHARGE PATIENTS	5,881.00	69,115.00
LITHOTRIPSY	47,652.00	0.00	NO CC/INVALID REV CODE	0.00	34.00
OTHER IMAGING SERVICE	231,965.00	20,319.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,413.00	11,814.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	195,916.00	46,656.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	414,807.00	45,483.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	176,333.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	135,335.00	1,856.00			
			TOTAL ANCILLARY	9,125,802.30	878,770.59
			TOTAL ACCOMODATIONS	0.00	507.00
			TOTAL CHARGES	9,125,802.30	879,277.59

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: 09/24/2013  
Run Time: 18:24:29  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5212322038548	01/03/12 - 01/03/12	12/03/12	0.00	34.00	0.00	0.00	0.00
TOTAL				0.00	34.00	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: 09/24/2013  
Run Time: 18:25:59  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	118,373.12	ADJUSTMENTS	0.00
COVERED CHARGES	103,381.77	CONTRACTUAL ALLOW	62,328.97
NON-COVERD CHARGES	14,991.35	TOTAL MEDICAID LIAB	41,052.80
		LESS: COB	41,038.29
		LESS: COPAYMENT	14.51
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	493.05	0.00	OTHER LAB	295.00	0.00
MED/SURG SUPPLY	3,381.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	68.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,053.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,578.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,635.00	824.00
EKG/ECG	1,392.00	883.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,926.90	857.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,139.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,612.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,084.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,913.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,348.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,936.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,224.82	1,762.99
RADIOLOGY THERAPEUTIC	27.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,976.00	231.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	704.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,186.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	617.36
OTHER IMAGING SERVICE	2,240.00	2,046.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,290.00	777.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,901.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,605.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	119.00	0.00			
			TOTAL ANCILLARY	103,381.77	14,743.35
			TOTAL ACCOMODATIONS	0.00	248.00
			TOTAL CHARGES	103,381.77	14,991.35

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
108	1112215003435	02/02/12 - 02/02/12	08/13/12	0.00	546.00	0.00	3,721.18	0.00
618	1112215003435	02/02/12 - 02/02/12	08/13/12	0.00	47.86	0.00	3,721.18	0.00
837	2312333000047	09/19/12 - 09/19/12	12/03/12	0.00	23.50	0.00	173.49	0.00
TOTAL				0.00	617.36	0.00	7,615.85	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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	488,302.70	ADJUSTMENTS	1,574.22
COVERED CHARGES	459,966.39	CONTRACTUAL ALLOW	424,868.33
NON-COVERD CHARGES	28,336.31	TOTAL MEDICAID LIAB	35,098.06
		LESS: COB	2,399.63
		LESS: COPAYMENT	1,035.06
		REIMBURSEMENT	31,663.37

TOTAL NUMBER OF CLAIMS 585

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,479.65	300.00	OTHER LAB	1,520.00	0.00
MED/SURG SUPPLY	304.00	1,936.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,503.00	436.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,605.00	1,854.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37,645.00	3,739.00
EKG/ECG	2,616.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	36,491.00	5,320.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	346.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,340.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,700.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	262,253.00	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	17,205.74	7,949.31
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	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,464.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,682.00	1,364.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,512.00	0.00			
			TOTAL ANCILLARY	459,966.39	28,336.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	459,966.39	28,336.31

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,231.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,795.00	CONTRACTUAL ALLOW	687.96
NON-COVERD CHARGES	436.00	TOTAL MEDICAID LIAB	2,107.04
		LESS: COB	2,098.04
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	73.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	46.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	307.00	307.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	226.00	10.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,215.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,795.00	436.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,795.00	436.00

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: 09/24/2013  
Run Time: 18:26:13  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	934,308.75	ADJUSTMENTS	37,873.64
COVERED CHARGES	659,434.60	CONTRACTUAL ALLOW	583,603.32
NON-COVERD CHARGES	274,874.15	TOTAL MEDICAID LIAB	75,831.28
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	75,747.28
		TOTAL NUMBER OF CLAIMS	14

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,464.67	0.00	OTHER LAB	2,723.00	0.00
MED/SURG SUPPLY	67,102.00	22,844.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,847.00	3,674.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	413.00	FEE SCHEDULE LAB	3,944.00	0.00
EKG/ECG	3,052.00	436.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	407,350.00	13,148.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,591.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,598.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,643.93	4,988.15
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	26,875.00	221,371.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,009.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50,849.00	8,000.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,386.00	0.00			
			TOTAL ANCILLARY	659,434.60	274,874.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	659,434.60	274,874.15

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: 09/24/2013  
Run Time: 18:26:15  
Page: 18

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:26:22  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER 000001834A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,215,912.52	ADJUSTMENTS	26,505.02
COVERED CHARGES	3,187,427.02	CONTRACTUAL ALLOW	1,961,881.19
NON-COVERD CHARGES	28,485.50	TOTAL MEDICAID LIAB	1,225,545.83
		LESS: COB	20,261.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,205,284.49

TOTAL NUMBER OF ADMISSIONS 224

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	510		0	269,330.00		22,645.00
ROUTINE NURSERY	54		0	22,525.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	564		0	291,855.00		22,645.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	366		2	424,950.00		1,550.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	366		2	424,950.00		1,550.00
TOTAL ACCOMODATIONS	930		2	716,805.00		24,195.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	559,246.81	0.00	OTHER LAB	7,255.75	0.00
MED/SURG SUPPLY	584,781.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	368,299.58	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,968.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	180,660.25	2,558.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,040.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,262.75	0.00	MRI SERVICES	20,901.25	0.00
IV THERAPY	21,625.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	68,879.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,748.69	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	183,235.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,323.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,180.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,553.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,394.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,031.75	0.00	INJECTABLE DRUGS	7,402.52	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	668.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,544.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,103.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,660.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,573.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,126.25	1,732.00			
AUDIOLOGY	1,837.50	0.00			
CARDIOLOGY	11,082.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,090.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	87,143.37	0.00			
			TOTAL ANCILLARY	2,470,622.02	4,290.50
			TOTAL ACCOMODATIONS	716,805.00	24,195.00
			TOTAL CHARGES	3,187,427.02	28,485.50

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 18:26:29  
Page: 4

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,106,643.20	ADJUSTMENTS	69,659.08
COVERED CHARGES	2,855,310.79	CONTRACTUAL ALLOW	1,820,780.16
NON-COVERD CHARGES	251,332.41	TOTAL MEDICAID LIAB	1,034,530.63
		LESS: COB	1,216.54
		LESS: COPAYMENT	3,459.07
		REIMBURSEMENT	1,029,855.02
		ALL OTHER	964,563.01
		FEE SCHEDULE-LAB	60,280.54
		INJECTABLE DRUGS	5,011.47

TOTAL NUMBER OF CLAIMS 2,455



STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER  
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197,423.54	47,056.84	OTHER LAB	42,350.25	0.00
MED/SURG SUPPLY	391,177.66	977.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,488.25	5,078.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	368,367.50	12,389.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	115,487.50	19,215.50	FEE SCHEDULE LAB	365,225.22	53,707.37
EKG/ECG	33,325.25	1,867.25	MRI SERVICES	149,054.25	0.00
IV THERAPY	39,250.00	2,525.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	99,162.54	20,693.46	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	468.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,370.25	7,998.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	62,427.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	24,722.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	357,563.75	5,899.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	79,860.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,879.60	16,186.40
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	8,346.75	1,496.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,232.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,060.00	14,857.98
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	66,532.75	2,703.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,095.00	2,407.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	83,083.50	19,601.91			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,148.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,054.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	144,386.23	15,438.25			
			TOTAL ANCILLARY	2,855,310.79	251,332.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,855,310.79	251,332.41

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,743.73	ADJUSTMENTS	0.00
COVERED CHARGES	76,165.54	CONTRACTUAL ALLOW	10,642.29
NON-COVERD CHARGES	17,578.19	TOTAL MEDICAID LIAB	65,523.25
		LESS: COB	65,514.73
		LESS: COPAYMENT	8.52
		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

STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER  
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,822.88	913.69	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,308.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,708.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,908.50	8,877.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,876.21	1,334.25
EKG/ECG	357.50	0.00	MRI SERVICES	1,693.75	0.00
IV THERAPY	660.00	245.00	PROFESSIONAL FEES	0.00	598.50
OPERATING ROOM	5,474.25	1,376.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	355.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	567.00	133.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,493.50	0.00	AMBULANCE	0.00	1,272.25
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,930.00	953.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,910.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,411.50	970.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,687.75	903.00			
			TOTAL ANCILLARY	76,165.54	17,578.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	76,165.54	17,578.19

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	286,109.37	ADJUSTMENTS	1,415.44
COVERED CHARGES	261,742.17	CONTRACTUAL ALLOW	230,434.57
NON-COVERD CHARGES	24,367.20	TOTAL MEDICAID LIAB	31,307.60
		LESS: COB	0.00
		LESS: COPAYMENT	972.00
		REIMBURSEMENT	30,335.60
		TOTAL NUMBER OF CLAIMS	560

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,570.95	6,670.43	OTHER LAB	599.25	0.00
MED/SURG SUPPLY	10,963.76	2,259.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,754.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,131.75	4,007.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	169.50	245.00	FEE SCHEDULE LAB	34,142.71	5,829.00
EKG/ECG	3,575.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,085.00	85.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,563.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,564.50	66.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,299.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	131,243.25	2,310.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	239.05
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	3,531.75	939.25			
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	1,347.75	1,716.00			
			TOTAL ANCILLARY	261,742.17	24,367.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	261,742.17	24,367.20

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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,202.82	ADJUSTMENTS	0.00
COVERED CHARGES	8,758.63	CONTRACTUAL ALLOW	3,608.55
NON-COVERD CHARGES	1,444.19	TOTAL MEDICAID LIAB	5,150.08
		LESS: COB	5,141.08
		LESS: COPAYMENT	9.00
		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: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29.88	115.44	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	210.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,235.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,870.75	0.00
EKG/ECG	357.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	193.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,035.50	140.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	995.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,758.63	1,444.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,758.63	1,444.19

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: 09/24/2013  
Run Time: 18:27:06  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	315,444.74	ADJUSTMENTS	54,725.19
COVERED CHARGES	304,083.26	CONTRACTUAL ALLOW	189,585.12
NON-COVERD CHARGES	11,361.48	TOTAL MEDICAID LIAB	114,498.14
		LESS: COB	0.00
		LESS: COPAYMENT	96.66
		REIMBURSEMENT	114,401.48
		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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,955.57	819.01	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	123,473.31	89.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,972.25	2,574.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	182.75	2,752.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,355.50	270.25
EKG/ECG	358.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	320.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,779.13	4,672.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	956.75	77.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,217.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	751.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	91,970.00	106.10
RADIOLOGY THERAPEUTIC	2,028.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	485.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	348.00	0.00			
			TOTAL ANCILLARY	304,083.26	11,361.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	304,083.26	11,361.48

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: 09/24/2013  
Run Time: 18:27:08  
Page: 14

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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:27:14  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER 000001845A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	202,243.19	ADJUSTMENTS	2,988.75
COVERED CHARGES	201,913.19	CONTRACTUAL ALLOW	72,748.01
NON-COVERD CHARGES	330.00	TOTAL MEDICAID LIAB	129,165.18
		LESS: COB	7,387.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	121,777.45

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	123		0	61,500.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	123		0	61,500.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	123		0	61,500.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,492.22	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23,046.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,271.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,989.93	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,152.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,231.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	594.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,464.38	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,974.40	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	296.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,350.00	330.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,001.00	0.00			
AMBULATORY SURGERY	0.00	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	0.00			
			TOTAL ANCILLARY	140,413.19	330.00
			TOTAL ACCOMODATIONS	61,500.00	0.00
			TOTAL CHARGES	201,913.19	330.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:27:15  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 18:27:15  
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STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	341,819.97	ADJUSTMENTS	12,103.39
COVERED CHARGES	308,071.54	CONTRACTUAL ALLOW	180,647.37
NON-COVERD CHARGES	33,748.43	TOTAL MEDICAID LIAB	127,424.17
		LESS: COB	0.00
		LESS: COPAYMENT	736.37
		REIMBURSEMENT	126,687.80
		ALL OTHER	114,145.17
		FEE SCHEDULE-LAB	12,542.63
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 394

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,271.05	0.00	OTHER LAB	3,358.00	0.00
MED/SURG SUPPLY	17,294.92	1,295.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	75.64	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,992.12	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,996.50	6,717.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,452.00	536.00	FEE SCHEDULE LAB	64,938.45	20,643.02
EKG/ECG	2,673.00	396.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,779.75	8.26	PROFESSIONAL FEES	0.00	35.00
OPERATING ROOM	2,734.96	321.76	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,826.38	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,024.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,190.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,256.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,557.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,050.00	1,320.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,001.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,675.00	2,400.00			
			TOTAL ANCILLARY	308,071.54	33,748.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	308,071.54	33,748.43

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: 09/24/2013  
Run Time: 18:27:21  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,412.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,394.40	CONTRACTUAL ALLOW	496.45
NON-COVERD CHARGES	18.00	TOTAL MEDICAID LIAB	897.95
		LESS: COB	897.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	198.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	175.63	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	262.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	698.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,394.40	18.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,394.40	18.00

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: 09/24/2013  
Run Time: 18:27:22  
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STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,262.89	ADJUSTMENTS	100.00
COVERED CHARGES	23,820.95	CONTRACTUAL ALLOW	21,020.95
NON-COVERD CHARGES	441.94	TOTAL MEDICAID LIAB	2,800.00
		LESS: COB	29.02
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	2,710.98
		TOTAL NUMBER OF CLAIMS	56

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,389.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	417.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,444.91	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,822.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,326.14	441.94
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	948.75	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	404.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,797.20	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	269.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,820.95	441.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,820.95	441.94

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: 09/24/2013  
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STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,228.98	ADJUSTMENTS	0.00
COVERED CHARGES	26,919.98	CONTRACTUAL ALLOW	22,579.68
NON-COVERD CHARGES	309.00	TOTAL MEDICAID LIAB	4,340.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,340.30

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: 09/24/2013  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,012.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	140.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	537.83	309.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	228.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,000.00	0.00			
			TOTAL ANCILLARY	26,919.98	309.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,919.98	309.00

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: 09/24/2013  
Run Time: 18:27:22  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:27:28  
 Page: 1

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,683.03	ADJUSTMENTS	0.00
COVERED CHARGES	75,361.23	CONTRACTUAL ALLOW	51,899.47
NON-COVERD CHARGES	7,321.80	TOTAL MEDICAID LIAB	23,461.76
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,461.76

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		4	10,077.00		7,321.80
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		4	10,077.00		7,321.80
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		4	10,077.00		7,321.80



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,986.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,319.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,340.68	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,610.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	3,679.08	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	6,348.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	104.59	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,894.35	0.00			
			TOTAL ANCILLARY	65,284.23	0.00
			TOTAL ACCOMODATIONS	10,077.00	7,321.80
			TOTAL CHARGES	75,361.23	7,321.80

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 18:27:29  
Page: 4

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,923,536.64	ADJUSTMENTS	66,194.01
COVERED CHARGES	1,721,262.41	CONTRACTUAL ALLOW	1,433,569.20
NON-COVERD CHARGES	202,274.23	TOTAL MEDICAID LIAB	287,693.21
		LESS: COB	290.91
		LESS: COPAYMENT	402.00
		REIMBURSEMENT	287,000.30
		ALL OTHER	268,905.74
		FEE SCHEDULE-LAB	16,758.51
		INJECTABLE DRUGS	1,336.05

TOTAL NUMBER OF CLAIMS 961

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,558.07	2,126.74	OTHER LAB	623.07	0.00
MED/SURG SUPPLY	54,788.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	170,454.44	5,351.03	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	203,538.39	55,851.22	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,812.67	10,554.04	FEE SCHEDULE LAB	288,230.80	94,812.05
EKG/ECG	31,717.10	420.93	MRI SERVICES	0.00	0.00
IV THERAPY	57,924.60	8,892.06	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	15,075.19	5,980.59	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	744,768.31	1,612.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,085.21	15,567.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	771.96	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,105.67	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,772.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,141.65	0.00			
			TOTAL ANCILLARY	1,721,262.41	202,274.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,721,262.41	202,274.23

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: 09/24/2013  
Run Time: 18:27:43  
Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,357.45	ADJUSTMENTS	0.00
COVERED CHARGES	7,568.27	CONTRACTUAL ALLOW	6,226.34
NON-COVERD CHARGES	789.18	TOTAL MEDICAID LIAB	1,341.93
		LESS: COB	1,341.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	111.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	435.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,782.60	635.66
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	675.79	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,449.72	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	1,032.28	153.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,568.27	789.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,568.27	789.18

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 18:27:43  
Page: 8

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	239,896.75	ADJUSTMENTS	1,199.00
COVERED CHARGES	230,170.03	CONTRACTUAL ALLOW	218,920.03
NON-COVERD CHARGES	9,726.72	TOTAL MEDICAID LIAB	11,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	384.01
		REIMBURSEMENT	10,865.99
		TOTAL NUMBER OF CLAIMS	225

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,492.46	4.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,578.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,715.36	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,504.67	2,538.27	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,082.60	4,151.50
EKG/ECG	862.91	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,633.59	623.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	563.67	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	158,313.40	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	10,423.34	2,408.61
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	230,170.03	9,726.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	230,170.03	9,726.72



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,130.32	ADJUSTMENTS	0.00
COVERED CHARGES	2,047.63	CONTRACTUAL ALLOW	1,737.11
NON-COVERD CHARGES	82.69	TOTAL MEDICAID LIAB	310.52
		LESS: COB	310.52
		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: 09/24/2013  
 Run Time: 18:27:46  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 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	136.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	814.35	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,096.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	82.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,047.63	82.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,047.63	82.69

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 18:27:47  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON  
 705 DIXIE ST  
 CARROLLTON,GA 30117-3818

PROVIDER NUMBER 000001867A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,648,870.73	ADJUSTMENTS	683,209.18
COVERED CHARGES	15,517,670.47	CONTRACTUAL ALLOW	10,573,858.78
NON-COVERD CHARGES	131,200.26	TOTAL MEDICAID LIAB	4,943,811.69
		LESS: COB	20,878.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,922,933.57

TOTAL NUMBER OF ADMISSIONS 574

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,377		6	1,230,665.00		4,034.00
ROUTINE NURSERY	219		0	114,630.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,596		6	1,345,295.00		4,034.00
SPECIAL CARE SERVICES						
CCU	647		0	897,973.00		0.00
ICU	242		0	513,336.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	889		0	1,411,309.00		0.00
TOTAL ACCOMODATIONS	2,485		6	2,756,604.00		4,034.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,100,167.14	894.17	OTHER LAB	129,896.33	0.00
MED/SURG SUPPLY	1,054,533.01	4,779.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,980,370.00	918.00	EDUCATION & TRAINING	2,646.00	84.00
RADIOLOGY-DIAGNOSTIC	229,014.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	458,200.00	10,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	104,133.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	97,120.00	0.00	MRI SERVICES	83,000.00	0.00
IV THERAPY	135,088.00	1,849.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,412,871.50	3,400.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	268,258.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	833,538.20	1,916.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	72,976.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	318,366.00	845.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	18,892.09
LABORATORY PATHOLOGIC	44,171.00	0.00	INJECTABLE DRUGS	917,800.97	220.00
RADIOLOGY THERAPEUTIC	208,964.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,172.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,252.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	10,212.00	54,656.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,810.00	1,438.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	882,408.22	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	53,063.00	9,626.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	286,805.00	9,810.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	212,484.00	1,860.00			
AUDIOLOGY	6,715.00	0.00			
CARDIOLOGY	725,461.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,860.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	85,711.00	5,479.00			
			TOTAL ANCILLARY	12,761,066.47	127,166.26
			TOTAL ACCOMODATIONS	2,756,604.00	4,034.00
			TOTAL CHARGES	15,517,670.47	131,200.26

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: 09/24/2013  
Run Time: 18:27:53  
Page: 3

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9711336960459	09/07/11 - 09/09/11	02/06/12	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

Run Date: 09/24/2013  
 Run Time: 18:28:09  
 Page: 4

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,872.34	ADJUSTMENTS	0.00
COVERED CHARGES	9,872.34	CONTRACTUAL ALLOW	9,872.34
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		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	1		0	893.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1		0	893.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1		0	893.00		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: 09/24/2013  
 Run Time: 18:28:09  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,299.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	812.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	504.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,197.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	166.00	0.00			
			TOTAL ANCILLARY	8,979.34	0.00
			TOTAL ACCOMODATIONS	893.00	0.00
			TOTAL CHARGES	9,872.34	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: 09/24/2013  
Run Time: 18:28:10  
Page: 6

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,193,613.21	ADJUSTMENTS	744,218.05
COVERED CHARGES	13,976,793.20	CONTRACTUAL ALLOW	10,589,628.26
NON-COVERD CHARGES	1,216,820.01	TOTAL MEDICAID LIAB	3,387,164.94
		LESS: COB	4,135.64
		LESS: COPAYMENT	11,085.00
		REIMBURSEMENT	3,371,944.30
		ALL OTHER	3,013,508.40
		FEE SCHEDULE-LAB	166,144.47
		INJECTABLE DRUGS	192,291.43

TOTAL NUMBER OF CLAIMS 6,441

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	737,347.91	15,689.89	OTHER LAB	140,254.97	213.80
MED/SURG SUPPLY	565,268.13	2,295.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	487.00	EDUCATION & TRAINING	42.00	604.00
RADIOLOGY-DIAGNOSTIC	579,481.00	45,656.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,716,407.00	67,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	340.00	5,683.00	FEE SCHEDULE LAB	1,813,377.90	310,242.80
EKG/ECG	163,810.00	5,610.00	MRI SERVICES	599,920.00	20,438.00
IV THERAPY	548,637.00	33,530.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,003,025.37	180,148.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,797.00	0.00	REHAB THERAPY	0.00	1,500.00
RESPIRATORY SERVICES	119,044.48	18,637.32	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	115,001.34	10,558.66	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,605,978.71	19,117.29	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,661.33
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	542,663.04	224,574.95
RADIOLOGY THERAPEUTIC	637,648.00	26,825.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	762.00	1,438.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,404.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	90,580.00	38,888.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	912,945.00	15,125.00	IMPL DEV CHARGE PATIENTS	36,198.01	4,580.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	439,459.00	31,606.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,729.00	2,918.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	338,574.00	24,552.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	507,886.34	89,249.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	164,365.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	553,251.00	7,787.00			
			TOTAL ANCILLARY	13,976,793.20	1,216,820.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,976,793.20	1,216,820.01

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: 09/24/2013  
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Page: 8

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,479.10	ADJUSTMENTS	0.00
COVERED CHARGES	21,193.10	CONTRACTUAL ALLOW	19,195.79
NON-COVERD CHARGES	7,286.00	TOTAL MEDICAID LIAB	1,997.31
		LESS: COB	1,982.31
		LESS: COPAYMENT	15.00
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	742.10	0.00	OTHER LAB	1,050.00	0.00
MED/SURG SUPPLY	217.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,629.00	503.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,225.00	1,218.00
EKG/ECG	200.00	0.00	MRI SERVICES	2,840.00	0.00
IV THERAPY	304.00	140.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	834.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	1,625.00
RESPIRATORY SERVICES	98.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,726.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,833.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	495.00	0.00			
			TOTAL ANCILLARY	21,193.10	7,286.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,193.10	7,286.00

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: 09/24/2013  
Run Time: 18:29:58  
Page: 10

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	592,985.90	ADJUSTMENTS	1,867.90
COVERED CHARGES	578,386.72	CONTRACTUAL ALLOW	535,480.74
NON-COVERD CHARGES	14,599.18	TOTAL MEDICAID LIAB	42,905.98
		LESS: COB	50.82
		LESS: COPAYMENT	1,398.00
		REIMBURSEMENT	41,457.16
		TOTAL NUMBER OF CLAIMS	767

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,766.75	43.00	OTHER LAB	9,930.00	0.00
MED/SURG SUPPLY	7,876.00	56.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,471.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,400.00	1,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	112,279.00	10,068.00
EKG/ECG	13,075.00	0.00	MRI SERVICES	2,840.00	0.00
IV THERAPY	24,198.00	836.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,634.00	250.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	270,622.75	883.25	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	6,836.22	84.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	138.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,770.00	640.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,450.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,238.00	0.00			
			TOTAL ANCILLARY	578,386.72	14,599.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	578,386.72	14,599.18

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: 09/24/2013  
Run Time: 18:30:10  
Page: 12

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,872.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,812.00	CONTRACTUAL ALLOW	1,430.42
NON-COVERD CHARGES	60.00	TOTAL MEDICAID LIAB	381.58
		LESS: COB	378.58
		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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	42.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	490.00	18.00
EKG/ECG	200.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	850.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,812.00	60.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,812.00	60.00

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: 09/24/2013  
Run Time: 18:30:11  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,214,684.61	ADJUSTMENTS	271,579.20
COVERED CHARGES	3,942,879.95	CONTRACTUAL ALLOW	3,209,680.95
NON-COVERD CHARGES	271,804.66	TOTAL MEDICAID LIAB	733,199.00
		LESS: COB	0.00
		LESS: COPAYMENT	2,166.00
		REIMBURSEMENT	731,033.00
		TOTAL NUMBER OF CLAIMS	140

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187,042.94	0.00	OTHER LAB	980.00	0.00
MED/SURG SUPPLY	181,962.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	42.00	266.00
RADIOLOGY-DIAGNOSTIC	50,402.00	20,422.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,880.00	5,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,798.00	FEE SCHEDULE LAB	72,367.30	21,222.10
EKG/ECG	11,660.00	200.00	MRI SERVICES	6,240.00	6,240.00
IV THERAPY	145,254.00	2,765.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	415,692.66	74,594.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,015.30	133.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,000.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,185.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,163.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	781,539.15	97,317.22
RADIOLOGY THERAPEUTIC	906,666.00	31,425.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	318.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,015.00	1,682.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	284,955.00	0.00	IMPL DEV CHARGE PATIENTS	384,599.57	625.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,813.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,070.00	570.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,080.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	346,273.00	7,027.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,983.00	0.00			
			TOTAL ANCILLARY	3,942,879.95	271,804.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,942,879.95	271,804.66

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 18:30:16  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:31:24  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL  
 247 S MAIN ST  
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER 000001878A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,928,909.32	ADJUSTMENTS	38,762.66
COVERED CHARGES	2,915,524.67	CONTRACTUAL ALLOW	2,515,276.05
NON-COVERD CHARGES	13,384.65	TOTAL MEDICAID LIAB	400,248.62
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	400,248.62

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	154		0	115,346.00		187.25
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	154		0	115,346.00		187.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	154		0	115,346.00		187.25

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:31:24  
 Page: 2

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105,922.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	76,928.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	84,157.24	0.00	EDUCATION & TRAINING	95.44	0.00
RADIOLOGY-DIAGNOSTIC	16,182.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,209.60	6,974.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,904.05	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,656.15	0.00	MRI SERVICES	3,900.00	0.00
IV THERAPY	2,643.67	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,068,312.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,386.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,877.40	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	51,124.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	352.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	676.92	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	276,394.84	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,081.50
OTHER IMAGING SERVICE	1,414.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,819.30	3,141.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	203.60	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	6,517.20	0.00			
			TOTAL ANCILLARY	2,800,178.67	13,197.40
			TOTAL ACCOMODATIONS	115,346.00	187.25
			TOTAL CHARGES	2,915,524.67	13,384.65

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: 09/24/2013  
Run Time: 18:31:24  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
106	2212333007604	09/14/12 - 09/19/12	12/03/12	0.00	3,081.50	0.00	0.00	0.00
TOTAL				0.00	3,081.50	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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 18:31:26  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,711,282.94	ADJUSTMENTS	81,168.37
COVERED CHARGES	3,671,529.46	CONTRACTUAL ALLOW	2,941,756.71
NON-COVERD CHARGES	1,039,753.48	TOTAL MEDICAID LIAB	729,772.75
		LESS: COB	71,903.85
		LESS: COPAYMENT	2,982.00
		REIMBURSEMENT	654,886.90
		ALL OTHER	603,938.30
		FEE SCHEDULE-LAB	50,564.18
		INJECTABLE DRUGS	384.42

TOTAL NUMBER OF CLAIMS 2,024

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134,807.59	41,542.82	OTHER LAB	120,964.30	96.96
MED/SURG SUPPLY	44,456.88	16,927.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	216,084.20	5,904.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	220,780.20	78,251.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,550.50	18,605.55	FEE SCHEDULE LAB	562,516.79	173,218.33
EKG/ECG	34,231.10	172.45	MRI SERVICES	218,606.30	14,228.40
IV THERAPY	14,154.21	4,935.22	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,736,283.26	660,589.76	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,159.30	2,174.30	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	217,861.85	2,256.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,863.70	4,432.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	499.40	7,438.35	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	796.06	704.51	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,713.17	5,685.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,283.15	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,107.05	1,570.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,812.20	1,018.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,998.25	0.00			
			TOTAL ANCILLARY	3,671,529.46	1,039,753.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,671,529.46	1,039,753.48

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,696.10	ADJUSTMENTS	0.00
COVERED CHARGES	18,026.25	CONTRACTUAL ALLOW	12,407.12
NON-COVERD CHARGES	669.85	TOTAL MEDICAID LIAB	5,619.13
		LESS: COB	5,613.13
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	583.85	334.85	OTHER LAB	1,700.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	740.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,222.60	335.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,134.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,325.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,026.25	669.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,026.25	669.85

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,780.68	ADJUSTMENTS	376.00
COVERED CHARGES	92,410.23	CONTRACTUAL ALLOW	84,232.91
NON-COVERD CHARGES	8,370.45	TOTAL MEDICAID LIAB	8,177.32
		LESS: COB	227.32
		LESS: COPAYMENT	321.00
		REIMBURSEMENT	7,629.00
		TOTAL NUMBER OF CLAIMS	159

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,619.80	2,279.95	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,282.25	1,022.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,992.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,719.60	1,695.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,540.93	3,004.50
EKG/ECG	1,034.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	457.90	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	533.60	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	42,925.40	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	1,387.50	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	915.80	0.00			
			TOTAL ANCILLARY	92,410.23	8,370.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,410.23	8,370.45

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: 09/24/2013  
Run Time: 18:31:57  
Page: 11

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 18:31:57  
Page: 12

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,813,815.47	ADJUSTMENTS	48,598.48
COVERED CHARGES	2,693,359.94	CONTRACTUAL ALLOW	2,379,949.04
NON-COVERD CHARGES	120,455.53	TOTAL MEDICAID LIAB	313,410.90
		LESS: COB	1,241.64
		LESS: COPAYMENT	153.72
		REIMBURSEMENT	312,015.54

TOTAL NUMBER OF CLAIMS 71



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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,660.54	32,921.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29,698.93	1,742.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
RADIOLOGY-DIAGNOSTIC	4,893.70	1,650.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,295.30	FEE SCHEDULE LAB	3,416.27	923.25
EKG/ECG	172.45	1,034.70	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,226,435.06	78,800.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,140.00	118.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,636.30	921.30
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	387,806.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,693,359.94	120,455.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,693,359.94	120,455.53

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 18:31:59  
Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:32:06  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TIFT REGIONAL MEDICAL CTR  
 901 18TH ST E  
 TIFTON,GA 31794-3648

PROVIDER NUMBER 000001922A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,411,423.08	ADJUSTMENTS	1,648,762.70
COVERED CHARGES	26,697,492.89	CONTRACTUAL ALLOW	18,526,900.38
NON-COVERD CHARGES	713,930.19	TOTAL MEDICAID LIAB	8,170,592.51
		LESS: COB	8,388.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,162,203.83

TOTAL NUMBER OF ADMISSIONS 953

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,969		8	1,832,095.00		226,430.00
ROUTINE NURSERY	245		0	132,135.00		16,115.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,214		8	1,964,230.00		242,545.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,053		0	1,566,750.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,053		0	1,566,750.00		0.00
TOTAL ACCOMODATIONS	4,267		8	3,530,980.00		242,545.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,572,678.57	940.84	OTHER LAB	111,283.75	0.00
MED/SURG SUPPLY	1,739,373.85	32,661.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,093,133.00	9,079.75	EDUCATION & TRAINING	97.00	0.00
RADIOLOGY-DIAGNOSTIC	597,862.00	0.00	OTHER THERAPEUTIC SVC	0.00	26,195.25
CT SCAN	956,294.25	1,022.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	162,195.25	106.75	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	417,831.50	0.00	MRI SERVICES	207,028.00	0.00
IV THERAPY	101,833.75	6,549.00	PROFESSIONAL FEES	0.00	1,969.00
OPERATING ROOM	1,482,456.00	22,451.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	105,880.50	0.00	REHAB THERAPY	1,944.00	0.00
RESPIRATORY SERVICES	1,316,919.50	5,121.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,921.50	370.50	AMBULANCE	0.00	0.00
GI SERVICES	155,731.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	645,770.00	1,300.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	176,254.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	115,102.00	0.00	INJECTABLE DRUGS	2,731,436.66	31.00
RADIOLOGY THERAPEUTIC	220,899.00	2,598.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,147.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,241.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	21,164.00	5,290.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,260.75	8,474.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,233,083.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	119,092.50	29,545.75			
BLOOD	561.25	0.00			
BLOOD STORAGE & PRO.	628,075.75	298,671.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	138,358.00	14,766.25			
AUDIOLOGY	21,926.00	0.00			
CARDIOLOGY	656,629.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,324.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	326,720.89	4,239.75			
			TOTAL ANCILLARY	23,166,512.89	471,385.19
			TOTAL ACCOMODATIONS	3,530,980.00	242,545.00
			TOTAL CHARGES	26,697,492.89	713,930.19

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:32:26  
 Page: 3

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,912.70	ADJUSTMENTS	0.00
COVERED CHARGES	44,771.95	CONTRACTUAL ALLOW	3,701.37
NON-COVERD CHARGES	2,140.75	TOTAL MEDICAID LIAB	41,070.58
		LESS: COB	41,070.58
		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	4		0	2,440.00		550.00
ROUTINE NURSERY	1		0	535.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	2,975.00		550.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,420.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	2,420.00		0.00
TOTAL ACCOMODATIONS	7		0	5,395.00		550.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,759.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,639.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,588.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	395.00	0.00	OTHER THERAPEUTIC SVC	0.00	330.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,315.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	406.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,929.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,917.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	161.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	709.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	678.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	772.25	0.00	INJECTABLE DRUGS	4,589.55	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	216.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	143.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,023.75	0.00			
AUDIOLOGY	220.50	0.00			
CARDIOLOGY	2,922.25	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	987.00	1,260.75			
			TOTAL ANCILLARY	39,376.95	1,590.75
			TOTAL ACCOMODATIONS	5,395.00	550.00
			TOTAL CHARGES	44,771.95	2,140.75

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: 09/24/2013  
Run Time: 18:32:28  
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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,606,073.22	ADJUSTMENTS	310,006.46
COVERED CHARGES	17,257,636.64	CONTRACTUAL ALLOW	13,781,377.18
NON-COVERD CHARGES	2,348,436.58	TOTAL MEDICAID LIAB	3,476,259.46
		LESS: COB	342.08
		LESS: COPAYMENT	11,350.38
		REIMBURSEMENT	3,464,567.00
		ALL OTHER	2,553,197.99
		FEE SCHEDULE-LAB	408,032.61
		INJECTABLE DRUGS	503,336.40

TOTAL NUMBER OF CLAIMS 8,493

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,004,952.79	22,283.49	OTHER LAB	430,189.50	13,963.50
MED/SURG SUPPLY	566,203.32	15,062.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	590.00	EDUCATION & TRAINING	3,306.00	84.00
RADIOLOGY-DIAGNOSTIC	748,541.25	16,347.50	OTHER THERAPEUTIC SVC	0.00	81,620.25
CT SCAN	1,601,238.00	299,269.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,363.50	17,497.00	FEE SCHEDULE LAB	3,722,867.19	617,020.37
EKG/ECG	289,047.00	2,605.25	MRI SERVICES	457,866.00	43,513.25
IV THERAPY	397,276.25	15,290.75	PROFESSIONAL FEES	0.00	323.75
OPERATING ROOM	936,329.26	519,459.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,705.75	314.00	REHAB THERAPY	2,332.00	0.00
RESPIRATORY SERVICES	100,020.25	1,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,991.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	148,197.50	69,538.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,958,043.25	29,822.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	261,664.75	2,025.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,423,986.81	360,607.13
RADIOLOGY THERAPEUTIC	366,605.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,099.00	1,368.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,559.00	2,830.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	609.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	77,517.25	12,116.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	131,834.50	3,211.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	531,459.00	37,499.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	126,066.50	54,292.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	268,290.25	2,912.00			
AUDIOLOGY	0.00	642.00			
CARDIOLOGY	392,935.00	102,849.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,510.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	233,638.27	1,355.10			
			TOTAL ANCILLARY	17,257,636.64	2,348,359.58
			TOTAL ACCOMODATIONS	0.00	77.00
			TOTAL CHARGES	17,257,636.64	2,348,436.58



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: 09/24/2013  
Run Time: 18:33:44  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	215,784.59	ADJUSTMENTS	0.00
COVERED CHARGES	158,619.36	CONTRACTUAL ALLOW	90,465.69
NON-COVERD CHARGES	57,165.23	TOTAL MEDICAID LIAB	68,153.67
		LESS: COB	68,022.99
		LESS: COPAYMENT	130.68
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,481.59	232.48	OTHER LAB	9,013.75	0.00
MED/SURG SUPPLY	5,693.25	32.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,722.75	0.00	OTHER THERAPEUTIC SVC	0.00	310.00
CT SCAN	12,824.75	14,095.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	6,461.00	FEE SCHEDULE LAB	44,046.25	7,941.00
EKG/ECG	4,324.00	202.25	MRI SERVICES	2,547.00	0.00
IV THERAPY	3,655.00	0.00	PROFESSIONAL FEES	0.00	8,077.00
OPERATING ROOM	7,107.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	323.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,641.75	157.25	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	20,065.50	1,088.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,312.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,261.42	1,832.25
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	1,539.00	422.75	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	2,760.25	12,756.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,849.00	3,102.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,715.75	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,723.00	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	1,336.10	131.00			
			TOTAL ANCILLARY	158,619.36	57,165.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	158,619.36	57,165.23

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: 09/24/2013  
Run Time: 18:33:48  
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TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	629,451.38	ADJUSTMENTS	883.04
COVERED CHARGES	596,962.51	CONTRACTUAL ALLOW	562,594.60
NON-COVERD CHARGES	32,488.87	TOTAL MEDICAID LIAB	34,367.91
		LESS: COB	0.00
		LESS: COPAYMENT	1,182.01
		REIMBURSEMENT	33,185.90
		TOTAL NUMBER OF CLAIMS	615

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,168.01	1,040.55	OTHER LAB	1,920.00	0.00
MED/SURG SUPPLY	8,480.25	1,402.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,283.75	0.00	OTHER THERAPEUTIC SVC	0.00	1,155.25
CT SCAN	34,217.00	7,501.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	159.75	FEE SCHEDULE LAB	162,574.00	14,062.25
EKG/ECG	10,088.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,482.25	1,781.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	314.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,323.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,128.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	255,203.25	1,721.25	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	19,634.05	938.07
RADIOLOGY THERAPEUTIC	2,237.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	54.50	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	14,440.00	2,672.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,409.00	0.00			
ONCOLOGY	53.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,892.20	0.00			
			TOTAL ANCILLARY	596,962.51	32,488.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	596,962.51	32,488.87

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,213.30	ADJUSTMENTS	0.00
COVERED CHARGES	4,499.80	CONTRACTUAL ALLOW	2,199.98
NON-COVERD CHARGES	713.50	TOTAL MEDICAID LIAB	2,299.82
		LESS: COB	2,293.82
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:33:53  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	387.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	93.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	282.50	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	1,484.25	0.00
EKG/ECG	196.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	215.75	0.00	PROFESSIONAL FEES	0.00	713.50
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,809.50	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	30.82	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
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	4,499.80	713.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,499.80	713.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
Run Time: 18:33:55  
Page: 13

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,733,562.01	ADJUSTMENTS	66,293.79
COVERED CHARGES	2,601,211.51	CONTRACTUAL ALLOW	2,254,688.22
NON-COVERD CHARGES	132,350.50	TOTAL MEDICAID LIAB	346,523.29
		LESS: COB	0.00
		LESS: COPAYMENT	450.00
		REIMBURSEMENT	346,073.29
		TOTAL NUMBER OF CLAIMS	68

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,682.23	578.25	OTHER LAB	3,350.00	0.00
MED/SURG SUPPLY	58,234.25	360.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,890.00	1,196.75	OTHER THERAPEUTIC SVC	0.00	9,155.25
CT SCAN	2,772.25	6,248.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,465.25	FEE SCHEDULE LAB	36,768.25	19,216.75
EKG/ECG	1,391.75	202.25	MRI SERVICES	0.00	5,488.75
IV THERAPY	37,580.75	1,842.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	128,271.75	43,046.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	243.00	0.00
RESPIRATORY SERVICES	1,168.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,602.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,545.50	220.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,116.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,587,450.08	7,962.50
RADIOLOGY THERAPEUTIC	104,636.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	657.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	339.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,453.75	1,884.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	492,825.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,142.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,644.00	6,532.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,568.50	510.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,213.00	25,443.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	651.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,009.45	0.00			
			TOTAL ANCILLARY	2,601,211.51	132,350.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,601,211.51	132,350.50



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 18:33:58  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:34:07  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIAWASSEE,GA 30546-0509

PROVIDER NUMBER 000001933A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,917.34	ADJUSTMENTS	4,045.29
COVERED CHARGES	57,717.34	CONTRACTUAL ALLOW	28,695.08
NON-COVERD CHARGES	1,200.00	TOTAL MEDICAID LIAB	29,022.26
		LESS: COB	1,063.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,958.76

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		0	7,200.00		1,200.00
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	12		0	7,200.00		1,200.00
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	12		0	7,200.00		1,200.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,749.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,218.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,816.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,220.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,975.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	990.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,171.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	600.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,206.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,501.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,500.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,571.34	0.00			
			TOTAL ANCILLARY	50,517.34	0.00
			TOTAL ACCOMODATIONS	7,200.00	1,200.00
			TOTAL CHARGES	57,717.34	1,200.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
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: 09/24/2013  
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CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	290,582.88	ADJUSTMENTS	4,708.44
COVERED CHARGES	239,376.48	CONTRACTUAL ALLOW	172,125.85
NON-COVERD CHARGES	51,206.40	TOTAL MEDICAID LIAB	67,250.63
		LESS: COB	0.00
		LESS: COPAYMENT	621.00
		REIMBURSEMENT	66,629.63
		ALL OTHER	54,056.54
		FEE SCHEDULE-LAB	12,381.71
		INJECTABLE DRUGS	191.38

TOTAL NUMBER OF CLAIMS 353

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,394.00	4,881.00	OTHER LAB	800.00	0.00
MED/SURG SUPPLY	4,864.00	191.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,945.00	800.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,875.00	13,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,625.00	1,560.00	FEE SCHEDULE LAB	90,222.00	24,759.00
EKG/ECG	4,272.00	0.00	MRI SERVICES	4,375.00	0.00
IV THERAPY	2,675.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,822.00	108.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,161.00	1,024.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,244.00	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	3,070.00	2,248.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	120.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,790.00	260.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,300.00	175.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,000.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,942.48	925.00			
			TOTAL ANCILLARY	239,376.48	51,206.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	239,376.48	51,206.40

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	223.00	ADJUSTMENTS	0.00
COVERED CHARGES	215.00	CONTRACTUAL ALLOW	62.84
NON-COVERD CHARGES	8.00	TOTAL MEDICAID LIAB	152.16
		LESS: COB	149.16
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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: 09/24/2013  
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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 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	215.00	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	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	215.00	8.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	215.00	8.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,218.00	ADJUSTMENTS	47.00
COVERED CHARGES	19,238.00	CONTRACTUAL ALLOW	17,452.95
NON-COVERD CHARGES	1,980.00	TOTAL MEDICAID LIAB	1,785.05
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	1,722.05
		TOTAL NUMBER OF CLAIMS	39

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	959.00	950.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	147.00	112.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,855.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,500.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,432.00	823.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,995.00	50.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	350.00	45.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,238.00	1,980.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,238.00	1,980.00

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  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:34:22  
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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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	771,417.90	ADJUSTMENTS	1,317.65
COVERED CHARGES	747,214.90	CONTRACTUAL ALLOW	287,585.77
NON-COVERD CHARGES	24,203.00	TOTAL MEDICAID LIAB	459,629.13
		LESS: COB	2,674.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	456,954.91

TOTAL NUMBER OF ADMISSIONS 78

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	189		0	113,400.00		12,150.00
ROUTINE NURSERY	0		19	0.00		7,500.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	189		19	113,400.00		19,650.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	35		0	42,350.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	35		0	42,350.00		0.00
TOTAL ACCOMODATIONS	224		19	155,750.00		19,650.00

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,354.30	0.00	OTHER LAB	7,600.00	0.00
MED/SURG SUPPLY	48,740.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	103,817.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,595.00	0.00	OTHER THERAPEUTIC SVC	0.00	150.00
CT SCAN	47,450.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	380.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,075.00	0.00	MRI SERVICES	1,975.00	1,500.00
IV THERAPY	2,975.00	0.00	PROFESSIONAL FEES	0.00	1,000.00
OPERATING ROOM	14,610.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,487.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,975.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,100.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,230.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,027.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,477.75	0.00	INJECTABLE DRUGS	111,641.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	100.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,000.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,631.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,450.00	1,903.00			
AUDIOLOGY	680.00	0.00			
CARDIOLOGY	20,246.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,846.37	0.00			
			TOTAL ANCILLARY	591,464.90	4,553.00
			TOTAL ACCOMODATIONS	155,750.00	19,650.00
			TOTAL CHARGES	747,214.90	24,203.00

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 05/01/11 THROUGH 04/30/12  
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: 09/24/2013  
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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,515,683.47	ADJUSTMENTS	94,891.30
COVERED CHARGES	1,404,219.19	CONTRACTUAL ALLOW	1,023,954.02
NON-COVERD CHARGES	111,464.28	TOTAL MEDICAID LIAB	380,265.17
		LESS: COB	785.69
		LESS: COPAYMENT	1,758.00
		REIMBURSEMENT	377,721.48
		ALL OTHER	333,964.65
		FEE SCHEDULE-LAB	42,492.31
		INJECTABLE DRUGS	1,264.52

TOTAL NUMBER OF CLAIMS 1,496

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,662.25	1,669.00	OTHER LAB	11,215.00	0.00
MED/SURG SUPPLY	49,457.06	86.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	134,385.00	2,710.00	OTHER THERAPEUTIC SVC	0.00	833.00
CT SCAN	212,950.00	8,650.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,355.00	1,000.00	FEE SCHEDULE LAB	253,948.45	61,952.00
EKG/ECG	23,751.00	330.00	MRI SERVICES	92,000.00	1,500.00
IV THERAPY	48,429.00	1,350.00	PROFESSIONAL FEES	0.00	500.00
OPERATING ROOM	58,726.00	2,082.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	797.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,611.00	40.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,050.00	2,550.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	188,542.00	743.98	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,275.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,161.25	5,884.75
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	700.00	184.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	766.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,894.80
OTHER IMAGING SERVICE	64,937.00	6,137.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,548.00	5,400.00			
ONCOLOGY	76.00	0.00			
NUCLEAR MEDICINE	28,225.00	5,201.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,163.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,254.68	0.00			
			TOTAL ANCILLARY	1,404,219.19	111,464.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,404,219.19	111,464.28

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
317	2011145070896	05/04/11 - 05/04/11	05/30/11	0.00	75.60	0.00	0.00	0.00
614	2011276040263	09/26/11 - 09/26/11	10/10/11	0.00	1,500.00	0.00	0.00	0.00
318	2011321083345	10/31/11 - 10/31/11	11/21/11	0.00	294.00	0.00	0.00	0.00
316	5212321005758	01/05/12 - 01/05/12	01/14/13	0.00	25.20	0.00	0.00	0.00
TOTAL				0.00	1,894.80	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,069.75	ADJUSTMENTS	0.00
COVERED CHARGES	30,068.25	CONTRACTUAL ALLOW	13,763.92
NON-COVERD CHARGES	5,001.50	TOTAL MEDICAID LIAB	16,304.33
		LESS: COB	16,286.33
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 33

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,312.00	0.00	OTHER LAB	750.00	0.00
MED/SURG SUPPLY	690.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,525.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,050.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,595.45	1,144.00
EKG/ECG	495.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	850.00	0.00	PROFESSIONAL FEES	0.00	2,090.00
OPERATING ROOM	882.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	224.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	450.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,005.00	30.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	250.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	800.00	112.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,189.00	1,625.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,068.25	5,001.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,068.25	5,001.50

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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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,138.40	ADJUSTMENTS	891.44
COVERED CHARGES	78,145.40	CONTRACTUAL ALLOW	70,091.81
NON-COVERD CHARGES	3,993.00	TOTAL MEDICAID LIAB	8,053.59
		LESS: COB	40.25
		LESS: COPAYMENT	315.03
		REIMBURSEMENT	7,698.31
		TOTAL NUMBER OF CLAIMS	163

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,774.00	86.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	432.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,005.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,700.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,247.00	2,102.00
EKG/ECG	1,320.00	0.00	MRI SERVICES	1,500.00	1,500.00
IV THERAPY	1,525.00	50.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,550.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,873.00	255.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,607.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,500.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,145.40	3,993.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,145.40	3,993.00

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: 09/24/2013  
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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,775.10	ADJUSTMENTS	0.00
COVERED CHARGES	1,699.10	CONTRACTUAL ALLOW	1,141.70
NON-COVERD CHARGES	76.00	TOTAL MEDICAID LIAB	557.40
		LESS: COB	554.40
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNION COUNTY HOSPITAL AUTHORITY  
 35 HOSPITAL RD  
 BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER  
 000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	29.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	225.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	455.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	100.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25.00	60.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,699.10	76.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,699.10	76.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION COUNTY HOSPITAL AUTHORITY  
35 HOSPITAL RD  
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER  
000001966A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
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: 09/24/2013  
Run Time: 18:35:03  
Page: 14

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	05/01/11	THROUGH	04/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA, GA 30901-2612

PROVIDER NUMBER 000001977A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,123,517.26	ADJUSTMENTS	2,075,563.75
COVERED CHARGES	38,686,128.53	CONTRACTUAL ALLOW	26,410,422.38
NON-COVERD CHARGES	437,388.73	TOTAL MEDICAID LIAB	12,275,706.15
		LESS: COB	214,520.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,061,186.12

TOTAL NUMBER OF ADMISSIONS 1,211

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,990		0	1,668,240.00		6,600.00
ROUTINE NURSERY	492		11	390,479.00		4,686.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		38,256.00
TOTAL ROUTINE	3,482		11	2,058,719.00		49,542.00
SPECIAL CARE SERVICES						
CCU	252		0	394,510.00		1,570.00
ICU	3,486		0	3,673,550.00		8,460.00
NICU	149		0	234,040.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,887		0	4,302,100.00		10,030.00
TOTAL ACCOMODATIONS	7,369		11	6,360,819.00		59,572.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,155,885.29	25,119.98	OTHER LAB	195,646.00	1,564.00
MED/SURG SUPPLY	5,087,527.59	126,942.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,264,515.17	26,866.00	EDUCATION & TRAINING	3,052.00	314.00
RADIOLOGY-DIAGNOSTIC	888,988.00	234.00	OTHER THERAPEUTIC SVC	60,831.10	3,072.40
CT SCAN	1,424,724.00	3,277.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	206,964.00	1,486.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	259,072.00	687.00	MRI SERVICES	379,565.00	0.00
IV THERAPY	345,690.00	11,043.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,889,138.00	36,880.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	242,491.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,875,624.00	5,786.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	159,616.00	3,220.00	AMBULANCE	0.00	0.00
GI SERVICES	185,473.00	3,012.00	CAST ROOM	355.00	0.00
EMERGENCY ROOM	741,726.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	126,141.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	447.58
LABORATORY PATHOLOGIC	193,187.00	706.00	INJECTABLE DRUGS	2,942,139.71	17,682.13
RADIOLOGY THERAPEUTIC	22,871.27	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	74,251.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	100,531.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	28,300.00	3,396.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,192.18	4,003.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,331,436.72	3,949.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,584.00
OTHER IMAGING SERVICE	211,944.00	56,385.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	330,992.50	28,688.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	172,182.00	720.00			
AUDIOLOGY	17,062.00	0.00			
CARDIOLOGY	1,224,606.00	2,664.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,925.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	159,665.00	5,088.00			
			TOTAL ANCILLARY	32,325,309.53	377,816.73
			TOTAL ACCOMODATIONS	6,360,819.00	59,572.00
			TOTAL CHARGES	38,686,128.53	437,388.73

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213248013948	12/08/12 - 01/15/13	09/09/13	0.00	4,584.00	0.00	0.00	0.00
TOTAL				0.00	4,584.00	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: 09/24/2013  
 Run Time: 18:35:44  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	341,781.90	ADJUSTMENTS	0.00
COVERED CHARGES	341,723.90	CONTRACTUAL ALLOW	159,576.86
NON-COVERD CHARGES	58.00	TOTAL MEDICAID LIAB	182,147.04
		LESS: COB	182,147.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	20

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	35		0	19,600.00		0.00
ROUTINE NURSERY	2		0	852.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	37		0	20,452.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	23		0	21,620.00		0.00
NICU	5		0	7,850.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	29,470.00		0.00
TOTAL ACCOMODATIONS	65		0	49,922.00		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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,642.43	0.00	OTHER LAB	750.00	0.00
MED/SURG SUPPLY	56,841.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	33,066.00	0.00	EDUCATION & TRAINING	34.00	0.00
RADIOLOGY-DIAGNOSTIC	11,661.00	0.00	OTHER THERAPEUTIC SVC	58.00	58.00
CT SCAN	11,678.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	180.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	916.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,814.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,372.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,552.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,278.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	678.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,682.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,544.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,198.00	0.00	INJECTABLE DRUGS	22,520.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,582.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,533.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	702.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,942.00	0.00			
AUDIOLOGY	114.00	0.00			
CARDIOLOGY	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	4,426.00	0.00			
			TOTAL ANCILLARY	291,801.90	58.00
			TOTAL ACCOMODATIONS	49,922.00	0.00
			TOTAL CHARGES	341,723.90	58.00



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: 09/24/2013  
Run Time: 18:35:47  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,923,361.85	ADJUSTMENTS	844,881.03
COVERED CHARGES	13,799,783.66	CONTRACTUAL ALLOW	10,797,843.61
NON-COVERD CHARGES	1,123,578.19	TOTAL MEDICAID LIAB	3,001,940.05
		LESS: COB	8,051.98
		LESS: COPAYMENT	10,314.92
		REIMBURSEMENT	2,983,573.15
		ALL OTHER	2,535,300.76
		FEE SCHEDULE-LAB	329,374.58
		INJECTABLE DRUGS	118,897.81

TOTAL NUMBER OF CLAIMS 9,826

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,111,157.92	1,788.39	OTHER LAB	175,574.00	0.00
MED/SURG SUPPLY	1,510,458.99	11,266.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	3,972.00
RADIOLOGY-DIAGNOSTIC	712,303.00	10,065.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,510,588.00	102,271.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,646.00	3,951.00	FEE SCHEDULE LAB	1,885,689.15	428,661.49
EKG/ECG	244,321.00	11,450.00	MRI SERVICES	376,612.00	20,723.00
IV THERAPY	402,281.50	31,399.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	733,198.00	133,919.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	53,762.00	0.00	REHAB THERAPY	200.00	0.00
RESPIRATORY SERVICES	249,228.00	15,215.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,208.00	198.00	AMBULANCE	0.00	0.00
GI SERVICES	129,446.50	6,992.50	CAST ROOM	6,222.00	461.00
EMERGENCY ROOM	1,968,412.50	22,158.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	141,810.00	1,028.00	DRUG-SPECIFIC/HOME IV	0.00	122.80
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	479,591.86	153,909.35
RADIOLOGY THERAPEUTIC	37,816.00	0.00	HOME HEALTH SERVICES	0.00	124.00
OCCUPATIONAL THERAPY	2,071.00	1,266.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,363.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	566.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	212,341.00	12,502.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	142,449.00	13,790.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	299,481.00	12,351.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	90,871.00	4,116.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	417,161.00	1,730.00			
AUDIOLOGY	1,668.00	2,208.00			
CARDIOLOGY	467,320.00	73,790.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,014.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	329,881.24	40,220.00			
			TOTAL ANCILLARY	13,799,783.66	1,123,578.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,799,783.66	1,123,578.19

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: 09/24/2013  
Run Time: 18:38:05  
Page: 8

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	160,481.57	ADJUSTMENTS	0.00
COVERED CHARGES	130,341.20	CONTRACTUAL ALLOW	72,558.82
NON-COVERD CHARGES	30,140.37	TOTAL MEDICAID LIAB	57,782.38
		LESS: COB	57,692.38
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 110

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA, GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,083.14	0.00	OTHER LAB	276.00	0.00
MED/SURG SUPPLY	16,871.87	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,202.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	11,327.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,480.00	5,056.00
EKG/ECG	1,603.00	0.00	MRI SERVICES	3,486.00	5,850.00
IV THERAPY	9,257.00	660.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,005.00	3,060.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,389.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,182.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,156.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,758.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,550.19	1,396.37
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,512.00	495.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	258.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	14.00
OTHER IMAGING SERVICE	4,274.00	1,040.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,942.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	5,328.00	1,242.00			
			TOTAL ANCILLARY	130,341.20	30,140.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	130,341.20	30,140.37

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8100	2212227009827	06/19/12 - 06/19/12	08/20/12	0.00	14.00	0.00	564.68	0.00
TOTAL				0.00	14.00	0.00	564.68	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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	362,972.87	ADJUSTMENTS	1,703.07
COVERED CHARGES	350,895.88	CONTRACTUAL ALLOW	317,891.28
NON-COVERD CHARGES	12,076.99	TOTAL MEDICAID LIAB	33,004.60
		LESS: COB	0.00
		LESS: COPAYMENT	1,245.06
		REIMBURSEMENT	31,759.54
		TOTAL NUMBER OF CLAIMS	590

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,815.87	0.00	OTHER LAB	1,500.00	0.00
MED/SURG SUPPLY	21,682.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,328.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,542.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37,774.00	8,599.00
EKG/ECG	8,339.00	229.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,198.00	990.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	237.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	262.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	191,470.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,735.10	443.99
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	140.00	825.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	153.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,625.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,094.00	990.00			
			TOTAL ANCILLARY	350,895.88	12,076.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	350,895.88	12,076.99

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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,951.91	ADJUSTMENTS	0.00
COVERED CHARGES	7,450.91	CONTRACTUAL ALLOW	5,918.41
NON-COVERD CHARGES	501.00	TOTAL MEDICAID LIAB	1,532.50
		LESS: COB	1,523.50
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	201.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	476.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	471.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,496.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	994.00	501.00
EKG/ECG	229.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	284.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,684.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	330.00	0.00			
			TOTAL ANCILLARY	7,450.91	501.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,450.91	501.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,577,247.60	ADJUSTMENTS	230,393.17
COVERED CHARGES	2,181,183.24	CONTRACTUAL ALLOW	1,731,649.96
NON-COVERD CHARGES	396,064.36	TOTAL MEDICAID LIAB	449,533.28
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	449,191.28
		TOTAL NUMBER OF CLAIMS	85

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,313.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	234,752.35	78.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,409.00	32,700.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,496.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	392.00	FEE SCHEDULE LAB	27,884.30	8,279.20
EKG/ECG	8,015.00	2,977.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,819.79	1,648.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	471,001.00	232,399.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	262.00	745.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,796.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,283.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	462,199.91	28,456.66
RADIOLOGY THERAPEUTIC	23,140.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	222.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	330.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	562,294.00	51,607.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,269.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,040.00	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	229,721.00	34,920.00			
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	26,265.00	944.00			
			TOTAL ANCILLARY	2,181,183.24	396,064.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,181,183.24	396,064.36

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,291.88	ADJUSTMENTS	0.00
COVERED CHARGES	57,257.88	CONTRACTUAL ALLOW	33,754.22
NON-COVERD CHARGES	20,034.00	TOTAL MEDICAID LIAB	23,503.66
		LESS: COB	23,497.66
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,341.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,458.86	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	916.00	100.00
EKG/ECG	229.00	458.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,445.00	2,445.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	188.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,296.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,650.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	749.96	947.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,437.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,485.00	15,896.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,250.00	0.00			
			TOTAL ANCILLARY	57,257.88	20,034.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,257.88	20,034.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER  
 801 W GORDON ST  
 THOMASTON,GA 30286-3426

PROVIDER NUMBER 000001988A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,605,484.90	ADJUSTMENTS	620,711.96
COVERED CHARGES	7,489,310.86	CONTRACTUAL ALLOW	4,265,695.87
NON-COVERD CHARGES	116,174.04	TOTAL MEDICAID LIAB	3,223,614.99
		LESS: COB	52,846.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,170,768.79

TOTAL NUMBER OF ADMISSIONS 412

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,069		0	964,243.00		51,274.00
ROUTINE NURSERY	48		0	33,600.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,117		0	997,843.00		51,274.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	392		0	607,600.00		0.00
NICU	43		0	43,000.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	435		0	650,600.00		0.00
TOTAL ACCOMODATIONS	1,552		0	1,648,443.00		51,274.00

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	436,433.27	71.25	OTHER LAB	13,304.00	0.00
MED/SURG SUPPLY	496,253.61	12,245.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,003,144.50	2,540.29	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	198,773.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	420,495.00	2,736.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	120,282.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	71,680.00	0.00	MRI SERVICES	33,352.00	0.00
IV THERAPY	157,376.00	1,291.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	685,521.00	15,176.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	77,898.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	400,839.00	2,062.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,696.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	91,065.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	321,692.00	100.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	129,025.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	20,512.50
LABORATORY PATHOLOGIC	25,514.00	0.00	INJECTABLE DRUGS	558,561.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,193.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,955.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	17,136.00	0.00	PATIENT CONVENIENCE	0.00	25.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	223,679.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	473.00
OTHER IMAGING SERVICE	51,117.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	104,920.00	661.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,026.00	4,665.00			
AUDIOLOGY	2,744.00	1,260.00			
CARDIOLOGY	99,470.00	1,082.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,684.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,039.00	0.00			
			TOTAL ANCILLARY	5,840,867.86	64,900.04
			TOTAL ACCOMODATIONS	1,648,443.00	51,274.00
			TOTAL CHARGES	7,489,310.86	116,174.04

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 09/24/2013  
Run Time: 18:38:34  
Page: 3

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
282	2213182002837	08/04/12 - 08/09/12	07/08/13	0.00	473.00	0.00	0.00	0.00
TOTAL				0.00	473.00	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: 09/24/2013  
 Run Time: 18:38:42  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,521.25	ADJUSTMENTS	0.00
COVERED CHARGES	50,061.25	CONTRACTUAL ALLOW	27,720.82
NON-COVERD CHARGES	460.00	TOTAL MEDICAID LIAB	22,340.43
		LESS: COB	22,340.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	8,150.00		400.00
ROUTINE NURSERY	3		0	2,100.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	10,250.00		400.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	10,250.00		400.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER  
 801 W GORDON ST  
 THOMASTON,GA 30286-3426

PROVIDER NUMBER  
 000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,912.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,545.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,590.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	593.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	280.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	262.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,770.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,367.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,587.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	319.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	820.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,985.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,294.00	0.00	INJECTABLE DRUGS	7,291.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	196.00	60.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	39,811.25	60.00
			TOTAL ACCOMODATIONS	10,250.00	400.00
			TOTAL CHARGES	50,061.25	460.00

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: 09/24/2013  
Run Time: 18:38:43  
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UPSON REGIONAL MEDICAL CENTER  
801 W GORDON ST  
THOMASTON,GA 30286-3426

PROVIDER NUMBER  
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,468,133.07	ADJUSTMENTS	622,478.57
COVERED CHARGES	9,887,822.39	CONTRACTUAL ALLOW	7,926,099.43
NON-COVERD CHARGES	580,310.68	TOTAL MEDICAID LIAB	1,961,722.96
		LESS: COB	2,821.56
		LESS: COPAYMENT	3,234.67
		REIMBURSEMENT	1,955,666.73
		ALL OTHER	1,716,971.37
		FEE SCHEDULE-LAB	188,816.55
		INJECTABLE DRUGS	49,878.81
		TOTAL NUMBER OF CLAIMS	4,537

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER  
 801 W GORDON ST  
 THOMASTON,GA 30286-3426

PROVIDER NUMBER  
 000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170,417.36	40.00	OTHER LAB	90,090.00	0.00
MED/SURG SUPPLY	278,454.60	154.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	639,147.00	11,290.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,498,934.00	25,330.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	39,464.00	4,687.00	FEE SCHEDULE LAB	1,880,094.72	244,590.75
EKG/ECG	182,534.00	8,120.00	MRI SERVICES	265,446.00	0.00
IV THERAPY	463,378.00	113,943.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	558,416.00	36,422.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,626.00	0.00	REHAB THERAPY	2,925.00	0.00
RESPIRATORY SERVICES	101,933.00	3,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	33,048.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	90,384.00	8,813.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,151,710.00	7,664.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	136,965.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	251,029.28	102,000.93
RADIOLOGY THERAPEUTIC	31,231.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,339.00	1,444.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	447.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,700.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	78,439.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	243,358.00	6,264.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,569.00	661.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	176,458.00	4,347.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	138,054.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	98,430.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	232,801.43	1,102.00			
			TOTAL ANCILLARY	9,887,822.39	580,310.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,887,822.39	580,310.68

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:39:38  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UPSON REGIONAL MEDICAL CENTER  
801 W GORDON ST  
THOMASTON,GA 30286-3426

PROVIDER NUMBER  
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	136,649.07	ADJUSTMENTS	0.00
COVERED CHARGES	126,556.07	CONTRACTUAL ALLOW	73,590.10
NON-COVERD CHARGES	10,093.00	TOTAL MEDICAID LIAB	52,965.97
		LESS: COB	52,914.97
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 62

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,757.11	40.00	OTHER LAB	999.00	0.00
MED/SURG SUPPLY	4,830.00	87.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,021.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,132.00	2,789.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,151.00	2,093.00
EKG/ECG	840.00	560.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,170.00	476.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,959.00	1.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,856.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,268.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	638.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,636.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,374.00	200.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,985.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,345.96	998.00
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,369.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,036.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,149.00	213.00			
			TOTAL ANCILLARY	126,556.07	10,093.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	126,556.07	10,093.00

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: 09/24/2013  
Run Time: 18:39:41  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	902,514.48	ADJUSTMENTS	3,589.20
COVERED CHARGES	883,061.63	CONTRACTUAL ALLOW	842,140.65
NON-COVERD CHARGES	19,452.85	TOTAL MEDICAID LIAB	40,920.98
		LESS: COB	0.00
		LESS: COPAYMENT	1,476.03
		REIMBURSEMENT	39,444.95
		TOTAL NUMBER OF CLAIMS	745

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,847.13	6.00	OTHER LAB	4,785.00	0.00
MED/SURG SUPPLY	17,006.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,764.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,330.00	2,067.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	162,406.00	9,369.00
EKG/ECG	7,560.00	0.00	MRI SERVICES	2,938.00	0.00
IV THERAPY	43,421.00	5,417.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,948.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	416.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,204.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	635.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	463,595.00	300.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,985.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,605.50	2,293.85
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	17,565.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,051.00	0.00			
			TOTAL ANCILLARY	883,061.63	19,452.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	883,061.63	19,452.85



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,514.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,880.00	CONTRACTUAL ALLOW	8,613.50
NON-COVERD CHARGES	634.00	TOTAL MEDICAID LIAB	5,266.50
		LESS: COB	5,257.50
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	146.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	865.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,499.00	620.00
EKG/ECG	280.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	685.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	140.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,077.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	736.00	14.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,439.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,880.00	634.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,880.00	634.00

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

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,621.88	ADJUSTMENTS	15,115.30
COVERED CHARGES	163,852.38	CONTRACTUAL ALLOW	134,764.52
NON-COVERD CHARGES	3,769.50	TOTAL MEDICAID LIAB	29,087.86
		LESS: COB	0.00
		LESS: COPAYMENT	134.69
		REIMBURSEMENT	28,953.17
		TOTAL NUMBER OF CLAIMS	6

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,101.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,534.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,527.00	1,121.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	500.00	FEE SCHEDULE LAB	7,017.00	1,177.00
EKG/ECG	560.00	0.00	MRI SERVICES	8,002.00	0.00
IV THERAPY	7,643.00	416.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,525.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,491.00	183.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,368.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,940.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,829.78	255.50
RADIOLOGY THERAPEUTIC	2,089.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,837.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,388.00	117.00			
			TOTAL ANCILLARY	163,852.38	3,769.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	163,852.38	3,769.50

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:39:58  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,319,709.11	ADJUSTMENTS	158,752.94
COVERED CHARGES	4,314,380.25	CONTRACTUAL ALLOW	3,424,770.32
NON-COVERD CHARGES	5,328.86	TOTAL MEDICAID LIAB	889,609.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	889,609.93

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	286		0	298,584.00		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	286		0	298,584.00		0.00
SPECIAL CARE SERVICES						
CCU	531		0	996,000.00		0.00
ICU	4		0	10,400.00		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	535		0	1,006,400.00		0.00
TOTAL ACCOMODATIONS	821		0	1,304,984.00		0.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	839,483.25	0.00	OTHER LAB	17,561.00	0.00
MED/SURG SUPPLY	114,044.00	462.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	410,807.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,853.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,534.00
CT SCAN	39,455.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,382.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,304.00	0.00	MRI SERVICES	12,091.00	0.00
IV THERAPY	24,164.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,480.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,179,522.00	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,258.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,787.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	53,155.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	28,026.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,222.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,580.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,557.00	3,332.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,495.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,170.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,009,396.25	5,328.86
			TOTAL ACCOMODATIONS	1,304,984.00	0.00
			TOTAL CHARGES	4,314,380.25	5,328.86

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:39:58  
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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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	860,158.25	ADJUSTMENTS	29,491.52
COVERED CHARGES	740,696.00	CONTRACTUAL ALLOW	499,898.31
NON-COVERD CHARGES	119,462.25	TOTAL MEDICAID LIAB	240,797.69
		LESS: COB	109.58
		LESS: COPAYMENT	708.00
		REIMBURSEMENT	239,980.11
		ALL OTHER	235,599.46
		FEE SCHEDULE-LAB	2,276.86
		INJECTABLE DRUGS	2,103.79

TOTAL NUMBER OF CLAIMS 237

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,986.00	941.25	OTHER LAB	903.00	0.00
MED/SURG SUPPLY	23,912.00	2,489.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	427.00	2,679.00
RADIOLOGY-DIAGNOSTIC	21,713.00	2,232.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,065.00	25,096.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,016.00	3,776.00	FEE SCHEDULE LAB	27,157.00	2,389.00
EKG/ECG	1,614.00	0.00	MRI SERVICES	64,381.00	8,236.00
IV THERAPY	705.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	102,168.00	44,949.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	6,558.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	61,790.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,528.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,781.00	0.00
RADIOLOGY THERAPEUTIC	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,227.00	2,982.00	IMPL DEV CHARGE PATIENTS	2,617.00	6,197.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,050.00
OTHER IMAGING SERVICE	38,785.00	2,766.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,786.00	4,110.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	280,634.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	3,012.00			
			TOTAL ANCILLARY	740,696.00	119,462.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	740,696.00	119,462.25

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: 09/24/2013  
 Run Time: 18:39:58  
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WELLSTAR WINDY HILL HOSPITAL  
 2540 WINDY HILL RD SE  
 MARIETTA,GA 30067-8605

PROVIDER NUMBER  
 000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2011280035975	09/26/11 - 09/26/11	10/10/11	0.00	75.00	0.00	0.00	0.00
948	2011280035975	09/28/11 - 09/28/11	10/10/11	0.00	75.00	0.00	0.00	0.00
948	5911286000745	08/01/11 - 08/01/11	10/17/11	0.00	75.00	0.00	0.00	0.00
948	5911286000745	08/02/11 - 08/02/11	10/17/11	0.00	150.00	0.00	0.00	0.00
948	5911286000745	08/03/11 - 08/03/11	10/17/11	0.00	75.00	0.00	0.00	0.00
948	5911286000745	08/22/11 - 08/22/11	10/17/11	0.00	75.00	0.00	0.00	0.00
948	5911286000745	08/23/11 - 08/23/11	10/17/11	0.00	75.00	0.00	0.00	0.00
948	5911286000745	08/24/11 - 08/24/11	10/17/11	0.00	75.00	0.00	0.00	0.00
948	5911334000850	10/04/11 - 10/04/11	12/05/11	0.00	150.00	0.00	0.00	0.00
948	5911334000850	10/18/11 - 10/18/11	12/05/11	0.00	150.00	0.00	0.00	0.00
948	5911334000850	10/25/11 - 10/25/11	12/05/11	0.00	75.00	0.00	0.00	0.00
TOTAL				0.00	1,050.00	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: 09/24/2013  
Run Time: 18:40:00  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL  
2540 WINDY HILL RD SE  
MARIETTA,GA 30067-8605

PROVIDER NUMBER  
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,984.00	ADJUSTMENTS	0.00
COVERED CHARGES	28,984.00	CONTRACTUAL ALLOW	10,726.37
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	18,257.63
		LESS: COB	18,242.63
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:40:00  
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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL  
 2540 WINDY HILL RD SE  
 MARIETTA,GA 30067-8605

PROVIDER NUMBER  
 000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	4,934.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	23,990.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,984.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,984.00	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL  
2540 WINDY HILL RD SE  
MARIETTA,GA 30067-8605

PROVIDER NUMBER  
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	502,199.75	ADJUSTMENTS	10,422.42
COVERED CHARGES	499,535.75	CONTRACTUAL ALLOW	400,494.26
NON-COVERD CHARGES	2,664.00	TOTAL MEDICAID LIAB	99,041.49
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	98,981.49
		TOTAL NUMBER OF CLAIMS	19



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 07/01/11 THROUGH 06/30/12  
 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	6,938.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,965.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,407.00	2,609.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,645.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,448.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	366.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,225.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,460.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	55.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,489.00	0.00
LITHOTRIPSY	368,592.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	499,535.75	2,664.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	499,535.75	2,664.00

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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR  
 3131 THOMASVILLE HWY  
 MOULTRIE,GA 31776-6925

PROVIDER NUMBER 000002021A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,120,155.53	ADJUSTMENTS	234,343.93
COVERED CHARGES	8,004,916.26	CONTRACTUAL ALLOW	4,473,017.61
NON-COVERD CHARGES	115,239.27	TOTAL MEDICAID LIAB	3,531,898.65
		LESS: COB	15,579.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,516,319.05

TOTAL NUMBER OF ADMISSIONS 603

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,461		0	765,945.00		67,235.00
ROUTINE NURSERY	283		0	132,408.00		960.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,744		0	898,353.00		68,195.00
SPECIAL CARE SERVICES						
CCU	311		0	266,838.00		0.00
ICU	165		0	196,845.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	476		0	463,683.00		0.00
TOTAL ACCOMODATIONS	2,220		0	1,362,036.00		68,195.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR  
 3131 THOMASVILLE HWY  
 MOULTRIE,GA 31776-6925

PROVIDER NUMBER  
 000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	971,588.36	60.00	OTHER LAB	18,994.00	0.00
MED/SURG SUPPLY	554,644.86	2,533.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,049,981.40	143.00	EDUCATION & TRAINING	6,394.00	61.00
RADIOLOGY-DIAGNOSTIC	170,110.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	354,147.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,768.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	57,820.00	0.00	MRI SERVICES	31,899.00	0.00
IV THERAPY	88,232.00	1,252.00	PROFESSIONAL FEES	0.00	60.00
OPERATING ROOM	766,859.32	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	138,894.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	256,678.00	4,511.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	113,937.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	73,657.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	233,636.00	324.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	94,568.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	56,549.00	0.00	INJECTABLE DRUGS	905,340.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,004.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,068.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	10,564.00	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	18,468.77	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	333,819.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	32,238.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	73,728.00	2,644.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	48,224.00	5,665.00			
AUDIOLOGY	12,772.00	0.00			
CARDIOLOGY	94,030.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49,609.00	11,322.00			
			TOTAL ANCILLARY	6,642,880.26	47,044.27
			TOTAL ACCOMODATIONS	1,362,036.00	68,195.00
			TOTAL CHARGES	8,004,916.26	115,239.27

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,217.41	ADJUSTMENTS	0.00
COVERED CHARGES	37,872.41	CONTRACTUAL ALLOW	11,037.39
NON-COVERD CHARGES	345.00	TOTAL MEDICAID LIAB	26,835.02
		LESS: COB	26,835.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	2,595.00		105.00
ROUTINE NURSERY	0		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	2,595.00		105.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	3,579.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	3,579.00		0.00
TOTAL ACCOMODATIONS	8		0	6,174.00		105.00

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,231.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,565.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,112.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,619.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,811.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	784.00	0.00	MRI SERVICES	0.00	240.00
IV THERAPY	1,130.00	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	1,728.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,508.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,897.56	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	498.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,251.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,563.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,698.41	240.00
			TOTAL ACCOMODATIONS	6,174.00	105.00
			TOTAL CHARGES	37,872.41	345.00

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: 09/24/2013  
Run Time: 18:40:22  
Page: 5

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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,844,169.29	ADJUSTMENTS	432,622.46
COVERED CHARGES	6,184,732.92	CONTRACTUAL ALLOW	4,422,434.79
NON-COVERD CHARGES	659,436.37	TOTAL MEDICAID LIAB	1,762,298.13
		LESS: COB	1,052.36
		LESS: COPAYMENT	7,446.97
		REIMBURSEMENT	1,753,798.80
		ALL OTHER	1,532,672.41
		FEE SCHEDULE-LAB	161,043.13
		INJECTABLE DRUGS	60,083.26

TOTAL NUMBER OF CLAIMS 5,332

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	229,796.29	7,828.39	OTHER LAB	53,356.00	542.00
MED/SURG SUPPLY	198,688.49	12,859.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	154.00	EDUCATION & TRAINING	479.00	1,129.00
RADIOLOGY-DIAGNOSTIC	317,320.00	14,616.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	863,212.00	20,490.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,348.00	7,360.00	FEE SCHEDULE LAB	777,928.70	188,053.50
EKG/ECG	67,925.00	1,372.00	MRI SERVICES	257,636.00	5,400.00
IV THERAPY	130,410.00	33,594.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	510,860.50	24,884.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,592.00	5,096.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	84,375.00	908.00	AMBULANCE	0.00	0.00
GI SERVICES	182,777.04	6,151.95	CAST ROOM	0.00	0.00
EMERGENCY ROOM	756,851.13	8,127.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,364.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	62.00	INJECTABLE DRUGS	239,148.17	148,988.12
RADIOLOGY THERAPEUTIC	12,610.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,390.00	3,244.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	770.00	265.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	345,967.60	46,237.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,417.00	51,841.00
LITHOTRIPSY	49,750.00	0.00	NO CC/INVALID REV CODE	0.00	106.61
OTHER IMAGING SERVICE	173,978.00	11,561.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,165.00	4,602.00			
ONCOLOGY	1,136.00	0.00			
NUCLEAR MEDICINE	222,682.00	25,410.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	291,591.00	13,719.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	89,425.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	130,784.00	14,834.00			
			TOTAL ANCILLARY	6,184,732.92	659,436.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,184,732.92	659,436.37



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
696	5912325001761	09/04/12 - 09/04/12	11/26/12	0.00	106.61	0.00	0.00	0.00
TOTAL				0.00	106.61	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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR  
3131 THOMASVILLE HWY  
MOULTRIE,GA 31776-6925

PROVIDER NUMBER  
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,007.97	ADJUSTMENTS	0.00
COVERED CHARGES	51,743.71	CONTRACTUAL ALLOW	9,285.47
NON-COVERD CHARGES	24,264.26	TOTAL MEDICAID LIAB	42,458.24
		LESS: COB	42,420.61
		LESS: COPAYMENT	37.63
		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

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,847.86	1,058.11	OTHER LAB	1,387.00	0.00
MED/SURG SUPPLY	2,389.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,265.00	638.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,627.00	7,990.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,719.00	882.00
EKG/ECG	392.00	0.00	MRI SERVICES	1,829.00	0.00
IV THERAPY	908.00	158.00	PROFESSIONAL FEES	0.00	120.00
OPERATING ROOM	8,763.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	878.50	438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,037.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,511.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,810.00	84.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,770.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	363.92	445.15
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	387.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,963.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,501.00	7,031.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	559.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,563.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,693.00	0.00			
			TOTAL ANCILLARY	51,743.71	24,264.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	51,743.71	24,264.26

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

Run Date: 09/24/2013  
Run Time: 18:41:39  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	325,106.80	ADJUSTMENTS	1,503.38
COVERED CHARGES	310,616.79	CONTRACTUAL ALLOW	283,304.69
NON-COVERD CHARGES	14,490.01	TOTAL MEDICAID LIAB	27,312.10
		LESS: COB	45.88
		LESS: COPAYMENT	684.04
		REIMBURSEMENT	26,582.18
		TOTAL NUMBER OF CLAIMS	491

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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,475.36	986.01	OTHER LAB	767.00	0.00
MED/SURG SUPPLY	5,119.44	305.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,458.00	720.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,951.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,675.00	6,614.00
EKG/ECG	3,627.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,028.00	952.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,220.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,463.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,382.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	177,175.00	504.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,054.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,358.99	1,926.90
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	185.00	42.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,677.00	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	2,001.00	0.00			
			TOTAL ANCILLARY	310,616.79	14,490.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	310,616.79	14,490.01

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,975.59	ADJUSTMENTS	0.00
COVERED CHARGES	6,915.95	CONTRACTUAL ALLOW	4,361.24
NON-COVERD CHARGES	59.64	TOTAL MEDICAID LIAB	2,554.71
		LESS: COB	2,548.71
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	71.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	206.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,327.00	55.00
EKG/ECG	196.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	308.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,180.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42.31	4.64
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
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	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,915.95	59.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,915.95	59.64

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR  
3131 THOMASVILLE HWY  
MOULTRIE,GA 31776-6925

PROVIDER NUMBER  
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	539,810.32	ADJUSTMENTS	15,182.88
COVERED CHARGES	511,862.04	CONTRACTUAL ALLOW	410,582.84
NON-COVERD CHARGES	27,948.28	TOTAL MEDICAID LIAB	101,279.20
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	101,015.20
		TOTAL NUMBER OF CLAIMS	20



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 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,052.02	116.47	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	39,642.93	9,319.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	61.00
RADIOLOGY-DIAGNOSTIC	2,554.00	490.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,559.00	2,259.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	595.00	0.00	FEE SCHEDULE LAB	8,540.00	897.00
EKG/ECG	196.00	0.00	MRI SERVICES	7,753.00	0.00
IV THERAPY	20,622.00	2,095.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,174.00	2,222.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,667.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,656.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,916.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	315,674.09	3,032.81
RADIOLOGY THERAPEUTIC	20,085.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,457.00	1,338.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	3,785.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,888.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	487.00	656.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,677.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,312.00	0.00			
			TOTAL ANCILLARY	511,862.04	27,948.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	511,862.04	27,948.28

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

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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	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA  
 601 DALLAS HWY  
 VILLA RICA,GA 30180-1202

PROVIDER NUMBER 000002032A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,128,802.02	ADJUSTMENTS	306,817.39
COVERED CHARGES	13,004,535.80	CONTRACTUAL ALLOW	6,171,810.65
NON-COVERD CHARGES	124,266.22	TOTAL MEDICAID LIAB	6,832,725.15
		LESS: COB	4,759.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,827,966.03

TOTAL NUMBER OF ADMISSIONS 1,507

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,672		0	7,270,901.00		102,832.00
ROUTINE NURSERY	77		0	40,810.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,749		0	7,311,711.00		102,832.00
SPECIAL CARE SERVICES						
CCU	190		0	263,910.00		0.00
ICU	125		0	265,000.00		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	315		0	528,910.00		0.00
TOTAL ACCOMODATIONS	8,064		0	7,840,621.00		102,832.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,605,453.38	64.96	OTHER LAB	31,974.00	0.00
MED/SURG SUPPLY	291,861.50	386.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,373,730.00	198.00	EDUCATION & TRAINING	901.00	42.00
RADIOLOGY-DIAGNOSTIC	61,498.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	172,692.00	980.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,655.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,920.00	0.00	MRI SERVICES	58,496.00	0.00
IV THERAPY	55,749.00	92.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	175,707.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	107,705.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	238,892.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	26,368.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	214,887.00	832.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,285.26
LABORATORY PATHOLOGIC	23,214.00	0.00	INJECTABLE DRUGS	358,796.52	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	4,133.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,140.00	13,616.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,634.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,210.00	IMPL DEV CHARGE PATIENTS	9,921.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,617.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	44,395.00	570.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	42,622.00	0.00			
AUDIOLOGY	3,081.00	0.00			
CARDIOLOGY	136,870.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,976.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,025.00	1,158.00			
			TOTAL ANCILLARY	5,163,914.80	21,434.22
			TOTAL ACCOMODATIONS	7,840,621.00	102,832.00
			TOTAL CHARGES	13,004,535.80	124,266.22

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:42:22  
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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 18:42:23  
Page: 4

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,344,814.14	ADJUSTMENTS	830,473.54
COVERED CHARGES	8,802,453.58	CONTRACTUAL ALLOW	5,780,449.66
NON-COVERD CHARGES	542,360.56	TOTAL MEDICAID LIAB	3,022,003.92
		LESS: COB	1,779.52
		LESS: COPAYMENT	5,541.00
		REIMBURSEMENT	3,014,683.40
		ALL OTHER	2,239,384.80
		FEE SCHEDULE-LAB	95,648.14
		INJECTABLE DRUGS	679,650.46
		TOTAL NUMBER OF CLAIMS	4,177

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	375,884.98	5,136.93	OTHER LAB	44,565.00	239.00
MED/SURG SUPPLY	220,399.52	302.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	302.00
RADIOLOGY-DIAGNOSTIC	357,231.00	10,014.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	854,000.00	93,000.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,133.00	FEE SCHEDULE LAB	1,039,844.40	154,576.00
EKG/ECG	90,320.00	3,200.00	MRI SERVICES	290,440.00	18,160.00
IV THERAPY	371,032.50	18,353.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	378,384.34	25,608.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,222.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,034.70	5,420.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	93,290.00	12,130.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,058,561.03	14,776.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	361.43
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,191,293.61	107,444.15
RADIOLOGY THERAPEUTIC	39,492.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	331.00	1,106.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,702.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,865.00	1,150.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,625,030.00	9,680.00	IMPL DEV CHARGE PATIENTS	8,720.50	3,077.52
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	227,331.00	29,870.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,718.00	2,986.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	133,230.00	5,952.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	95,119.00	13,647.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	107,507.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	103,607.00	1,033.00			
			TOTAL ANCILLARY	8,802,453.58	542,360.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,802,453.58	542,360.56

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: 09/24/2013  
Run Time: 18:43:17  
Page: 6

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,625.70	ADJUSTMENTS	0.00
COVERED CHARGES	6,101.04	CONTRACTUAL ALLOW	3,820.43
NON-COVERD CHARGES	4,524.66	TOTAL MEDICAID LIAB	2,280.61
		LESS: COB	2,277.61
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253.70	63.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	359.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,400.00	224.00
EKG/ECG	200.00	200.00	MRI SERVICES	0.00	0.00
IV THERAPY	111.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,027.34	267.66	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	500.00	570.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,101.04	4,524.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,101.04	4,524.66

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 18:43:18  
Page: 8

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	485,847.67	ADJUSTMENTS	1,603.16
COVERED CHARGES	475,082.84	CONTRACTUAL ALLOW	435,253.56
NON-COVERD CHARGES	10,764.83	TOTAL MEDICAID LIAB	39,829.28
		LESS: COB	21.36
		LESS: COPAYMENT	1,392.07
		REIMBURSEMENT	38,415.85
		TOTAL NUMBER OF CLAIMS	712

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,505.70	0.00	OTHER LAB	1,240.00	0.00
MED/SURG SUPPLY	7,624.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,609.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,000.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	81,819.00	7,634.00
EKG/ECG	5,800.00	0.00	MRI SERVICES	2,840.00	0.00
IV THERAPY	25,953.00	582.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,144.00	121.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	666.00	666.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	238,320.17	672.83	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,841.97	175.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	147.00	184.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,540.00	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	1,905.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,128.00	0.00			
			TOTAL ANCILLARY	475,082.84	10,764.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	475,082.84	10,764.83

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,394.46	ADJUSTMENTS	0.00
COVERED CHARGES	1,329.46	CONTRACTUAL ALLOW	905.92
NON-COVERD CHARGES	65.00	TOTAL MEDICAID LIAB	423.54
		LESS: COB	420.54
		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  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	188.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	213.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	65.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	928.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,329.46	65.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,329.46	65.00

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

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,058,274.74	ADJUSTMENTS	57,120.20
COVERED CHARGES	980,052.30	CONTRACTUAL ALLOW	688,326.18
NON-COVERD CHARGES	78,222.44	TOTAL MEDICAID LIAB	291,726.12
		LESS: COB	0.00
		LESS: COPAYMENT	453.00
		REIMBURSEMENT	291,273.12
		TOTAL NUMBER OF CLAIMS	51

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA  
 601 DALLAS HWY  
 VILLA RICA,GA 30180-1202

PROVIDER NUMBER  
 000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,344.49	930.00	OTHER LAB	620.00	0.00
MED/SURG SUPPLY	81,576.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,604.00	725.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,000.00	5,100.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,899.00	2,849.30
EKG/ECG	2,400.00	0.00	MRI SERVICES	2,840.00	0.00
IV THERAPY	36,152.00	3,143.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	119,933.82	59,750.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,578.50	465.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,332.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,658.75	360.25	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	60,261.11	2,947.21
RADIOLOGY THERAPEUTIC	1,859.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	266.00	92.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	501,545.00	0.00	IMPL DEV CHARGE PATIENTS	12,894.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,020.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,800.00	1,860.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,634.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,833.00	0.00			
			TOTAL ANCILLARY	980,052.30	78,222.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	980,052.30	78,222.44

Report : CLM-0814-0  
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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

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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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NORTH GEORGIA MEDICAL CENTER  
 1362 S MAIN ST  
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER 000002043A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	965,612.42	ADJUSTMENTS	9,834.69
COVERED CHARGES	955,448.87	CONTRACTUAL ALLOW	558,132.97
NON-COVERD CHARGES	10,163.55	TOTAL MEDICAID LIAB	397,315.90
		LESS: COB	2,746.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	394,569.65

TOTAL NUMBER OF ADMISSIONS 56

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	140		0	40,922.66		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	140		0	40,922.66		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	61		0	61,649.60		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	61		0	61,649.60		0.00
TOTAL ACCOMODATIONS	201		0	102,572.26		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: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER  
 1362 S MAIN ST  
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213,764.59	0.00	OTHER LAB	1,247.90	0.00
MED/SURG SUPPLY	82,182.12	63.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	151,130.54	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,609.90	0.00	OTHER THERAPEUTIC SVC	0.00	5,428.00
CT SCAN	36,705.09	3,434.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,040.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,242.45	0.00	MRI SERVICES	862.64	0.00
IV THERAPY	107,103.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,909.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,142.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,225.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,143.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,815.42	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	625.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34.91	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,835.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	900.00
OTHER IMAGING SERVICE	2,775.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,287.30	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,448.85	338.35			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	700.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,530.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,115.50	0.00			
			TOTAL ANCILLARY	852,876.61	10,163.55
			TOTAL ACCOMODATIONS	102,572.26	0.00
			TOTAL CHARGES	955,448.87	10,163.55

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: 09/24/2013  
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NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
405	2212191006850	04/05/12 - 04/08/12	07/16/12	0.00	900.00	0.00	0.00	0.00
TOTAL				0.00	900.00	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: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,213,127.74	ADJUSTMENTS	30,027.14
COVERED CHARGES	2,074,226.34	CONTRACTUAL ALLOW	1,636,872.46
NON-COVERD CHARGES	138,901.40	TOTAL MEDICAID LIAB	437,353.88
		LESS: COB	211.57
		LESS: COPAYMENT	2,205.00
		REIMBURSEMENT	434,937.31
		ALL OTHER	385,191.08
		FEE SCHEDULE-LAB	49,746.23
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,765

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER  
 1362 S MAIN ST  
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	159,157.31	543.73	OTHER LAB	15,279.25	0.00
MED/SURG SUPPLY	116,533.16	1,497.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	125.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,681.03	4,292.65	OTHER THERAPEUTIC SVC	0.00	3,207.00
CT SCAN	111,490.12	5,696.02	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	513.40	FEE SCHEDULE LAB	350,410.10	74,608.03
EKG/ECG	53,902.40	557.85	MRI SERVICES	26,856.84	0.00
IV THERAPY	159,972.15	18,039.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	166,059.30	13,156.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,936.90	1,527.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	57,292.45	1,145.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	469,488.21	232.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,866.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	2,323.64
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	2,649.30	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	9,437.45	296.90	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,005.50	1,066.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,993.55	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,499.70	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	57,918.50	7,215.90			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,932.55	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,513.27	207.53			
			TOTAL ANCILLARY	2,074,226.34	138,901.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,074,226.34	138,901.40

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,334.39	ADJUSTMENTS	0.00
COVERED CHARGES	11,590.49	CONTRACTUAL ALLOW	4,657.38
NON-COVERD CHARGES	5,743.90	TOTAL MEDICAID LIAB	6,933.11
		LESS: COB	6,921.11
		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

NORTH GEORGIA MEDICAL CENTER  
 1362 S MAIN ST  
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	713.93	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,086.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	202.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,317.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	512.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,364.46	555.25
EKG/ECG	182.00	0.00	MRI SERVICES	0.00	956.65
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,029.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	70.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,340.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	795.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,207.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,590.49	5,743.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,590.49	5,743.90



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: 09/24/2013  
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NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,168.41	ADJUSTMENTS	105.88
COVERED CHARGES	163,433.46	CONTRACTUAL ALLOW	153,140.50
NON-COVERD CHARGES	3,734.95	TOTAL MEDICAID LIAB	10,292.96
		LESS: COB	0.00
		LESS: COPAYMENT	348.00
		REIMBURSEMENT	9,944.96
		TOTAL NUMBER OF CLAIMS	184

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER  
 1362 S MAIN ST  
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,425.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,519.45	185.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,423.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,508.43	512.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,043.43	2,816.75
EKG/ECG	2,647.00	0.00	MRI SERVICES	862.64	0.00
IV THERAPY	5,322.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	672.95	30.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	97,671.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	190.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	434.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	902.50	0.00			
			TOTAL ANCILLARY	163,433.46	3,734.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	163,433.46	3,734.95

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: 09/24/2013  
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NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	655.80	ADJUSTMENTS	0.00
COVERED CHARGES	655.80	CONTRACTUAL ALLOW	473.83
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	181.97
		LESS: COB	181.97
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER  
 1362 S MAIN ST  
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	105.80	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	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	550.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	655.80	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	655.80	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 18:44:08  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL  
 865 S 1ST ST  
 JESUP,GA 31545-0210

PROVIDER NUMBER 000002054A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,634,880.32	ADJUSTMENTS	99,742.43
COVERED CHARGES	4,607,949.32	CONTRACTUAL ALLOW	2,777,397.68
NON-COVERD CHARGES	26,931.00	TOTAL MEDICAID LIAB	1,830,551.64
		LESS: COB	10,325.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,820,225.94

TOTAL NUMBER OF ADMISSIONS 321

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,036		0	454,803.00		22,914.00
ROUTINE NURSERY	106		0	28,832.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,142		0	483,635.00		22,914.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	191		0	205,516.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	191		0	205,516.00		0.00
TOTAL ACCOMODATIONS	1,333		0	689,151.00		22,914.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,130,987.48	0.00	OTHER LAB	12,714.00	0.00
MED/SURG SUPPLY	803,341.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	659,025.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,475.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	290,225.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,979.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	32,000.00	0.00	MRI SERVICES	40,206.00	0.00
IV THERAPY	75,103.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	220,509.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,258.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,268.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,588.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	95,273.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,802.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,291.00	117.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,840.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,809.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,485.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,078.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,833.00	0.00
LITHOTRIPSY	59,556.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,427.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,805.00	366.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,218.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,219.00	0.00			
AMBULATORY SURGERY	3,009.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	75,552.49	456.00			
			TOTAL ANCILLARY	3,918,798.32	4,017.00
			TOTAL ACCOMODATIONS	689,151.00	22,914.00
			TOTAL CHARGES	4,607,949.32	26,931.00



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,137.41	ADJUSTMENTS	0.00
COVERED CHARGES	58,829.41	CONTRACTUAL ALLOW	19,776.05
NON-COVERD CHARGES	308.00	TOTAL MEDICAID LIAB	39,053.36
		LESS: COB	39,053.36
		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	14		0	6,146.00		308.00
ROUTINE NURSERY	3		0	816.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17		0	6,962.00		308.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	6,962.00		308.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL  
 865 S 1ST ST  
 JESUP,GA 31545-0210

PROVIDER NUMBER  
 000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,026.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,628.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,061.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	128.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	267.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,960.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,538.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,704.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,341.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	736.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	478.06	0.00			
			TOTAL ANCILLARY	51,867.41	0.00
			TOTAL ACCOMODATIONS	6,962.00	308.00
			TOTAL CHARGES	58,829.41	308.00

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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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,447,459.67	ADJUSTMENTS	439,210.56
COVERED CHARGES	4,191,381.59	CONTRACTUAL ALLOW	3,174,681.94
NON-COVERD CHARGES	256,078.08	TOTAL MEDICAID LIAB	1,016,699.65
		LESS: COB	1,582.75
		LESS: COPAYMENT	3,417.00
		REIMBURSEMENT	1,011,699.90
		ALL OTHER	912,757.85
		FEE SCHEDULE-LAB	93,393.61
		INJECTABLE DRUGS	5,548.44
		TOTAL NUMBER OF CLAIMS	3,313

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313,465.76	1,049.00	OTHER LAB	30,283.00	0.00
MED/SURG SUPPLY	534,209.93	1,676.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	182,269.00	4,050.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	588,308.00	30,210.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,828.00	2,759.00	FEE SCHEDULE LAB	672,905.30	156,093.60
EKG/ECG	51,584.00	640.00	MRI SERVICES	171,479.00	5,129.00
IV THERAPY	152,643.00	7,450.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	359,702.50	13,303.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,366.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,721.00	524.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,636.00	210.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	542,104.00	3,420.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,721.00	297.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	83,130.02	13,121.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,417.00	283.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,514.00	1,431.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,270.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	62,247.00	0.00	NO CC/INVALID REV CODE	0.00	71.00
OTHER IMAGING SERVICE	107,865.00	10,262.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,457.00	1,557.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,610.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,879.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	117,767.08	2,541.98			
			TOTAL ANCILLARY	4,191,381.59	256,078.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,191,381.59	256,078.08

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	2212121004887	03/28/12 - 03/28/12	05/07/12	0.00	71.00	0.00	0.00	0.00
TOTAL				0.00	71.00	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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	87,060.15	ADJUSTMENTS	0.00
COVERED CHARGES	74,147.15	CONTRACTUAL ALLOW	26,814.98
NON-COVERD CHARGES	12,913.00	TOTAL MEDICAID LIAB	47,332.17
		LESS: COB	47,302.17
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 57

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,791.00	15.00	OTHER LAB	615.00	0.00
MED/SURG SUPPLY	12,659.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,786.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,089.00	6,873.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,347.00	1,215.00
EKG/ECG	384.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,164.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,485.00	3,906.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	456.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	156.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,590.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,134.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,566.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,630.00	843.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,328.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	61.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,166.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	485.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,316.15	0.00			
			TOTAL ANCILLARY	74,147.15	12,913.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	74,147.15	12,913.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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WAYNE MEMORIAL HOSPITAL  
865 S 1ST ST  
JESUP,GA 31545-0210

PROVIDER NUMBER  
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	332,985.06	ADJUSTMENTS	2,253.47
COVERED CHARGES	319,575.06	CONTRACTUAL ALLOW	285,116.02
NON-COVERD CHARGES	13,410.00	TOTAL MEDICAID LIAB	34,459.04
		LESS: COB	29.35
		LESS: COPAYMENT	1,239.01
		REIMBURSEMENT	33,190.68
		TOTAL NUMBER OF CLAIMS	616



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,936.00	112.00	OTHER LAB	1,845.00	0.00
MED/SURG SUPPLY	11,316.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,738.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,430.00	2,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,152.00	6,339.00
EKG/ECG	3,072.00	0.00	MRI SERVICES	3,422.00	0.00
IV THERAPY	18,463.00	734.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	912.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	435.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	160,146.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,267.00	2,581.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,927.00	1,355.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,514.06	0.00			
			TOTAL ANCILLARY	319,575.06	13,410.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	319,575.06	13,410.00

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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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,835.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,955.00	CONTRACTUAL ALLOW	1,036.30
NON-COVERD CHARGES	1,880.00	TOTAL MEDICAID LIAB	3,918.70
		LESS: COB	3,900.70
		LESS: COPAYMENT	18.00
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	180.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	93.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	420.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,528.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	891.00	72.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	76.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,122.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	105.00	280.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,955.00	1,880.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,955.00	1,880.00

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

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	409,862.40	ADJUSTMENTS	76,149.50
COVERED CHARGES	408,045.40	CONTRACTUAL ALLOW	311,484.74
NON-COVERD CHARGES	1,817.00	TOTAL MEDICAID LIAB	96,560.66
		LESS: COB	0.00
		LESS: COPAYMENT	88.60
		REIMBURSEMENT	96,472.06

TOTAL NUMBER OF CLAIMS 19

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,647.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100,726.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,059.00	510.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,289.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	312.00	FEE SCHEDULE LAB	4,813.00	350.00
EKG/ECG	1,408.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	506.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	59,544.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	740.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,334.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	396.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,668.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,568.00	645.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	191,631.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	716.40	0.00			
			TOTAL ANCILLARY	408,045.40	1,817.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	408,045.40	1,817.00

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL  
865 S 1ST ST  
JESUP,GA 31545-0210

PROVIDER NUMBER  
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,435.00	ADJUSTMENTS	0.00
COVERED CHARGES	20,054.00	CONTRACTUAL ALLOW	4,552.06
NON-COVERD CHARGES	381.00	TOTAL MEDICAID LIAB	15,501.94
		LESS: COB	15,495.94
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	542.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	868.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	180.00	21.00
EKG/ECG	128.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	444.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	270.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	125.00	232.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	17,457.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	128.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	20,054.00	381.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,054.00	381.00

\*\* 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: 09/24/2013  
 Run Time: 18:45:27  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER 000002065A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,092,437.85	ADJUSTMENTS	780,770.27
COVERED CHARGES	12,904,330.50	CONTRACTUAL ALLOW	8,076,293.00
NON-COVERD CHARGES	188,107.35	TOTAL MEDICAID LIAB	4,828,037.50
		LESS: COB	56,724.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,771,312.81

TOTAL NUMBER OF ADMISSIONS 726

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,213		0	994,305.00		54,075.00
ROUTINE NURSERY	175		0	86,125.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,388		0	1,080,430.00		54,075.00
SPECIAL CARE SERVICES						
CCU	1,159		0	1,713,380.00		0.00
ICU	342		0	656,640.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,501		0	2,370,020.00		0.00
TOTAL ACCOMODATIONS	2,889		0	3,450,450.00		54,075.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,690,721.02	0.00	OTHER LAB	44,722.45	0.00
MED/SURG SUPPLY	645,404.70	5,088.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,465,245.20	0.00	EDUCATION & TRAINING	2,984.50	0.00
RADIOLOGY-DIAGNOSTIC	195,596.70	0.00	OTHER THERAPEUTIC SVC	0.00	3,353.70
CT SCAN	542,692.35	35,528.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	84,941.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	92,208.10	0.00	MRI SERVICES	84,717.25	0.00
IV THERAPY	10,812.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,234,348.45	0.00	DURABLE MED. EQUIP.	0.00	5.40
LABOR/DELIVERY ROOM	214,750.35	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	437,642.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	305,398.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	121,430.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	764,548.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,576.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	58,480.45	0.00	INJECTABLE DRUGS	1,020.87	0.00
RADIOLOGY THERAPEUTIC	27,672.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,564.80	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	50,738.40	5,382.60	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	482.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	377,472.11	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	80,842.30	26,298.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	174,883.75	49,894.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	68,683.95	6,977.95			
AUDIOLOGY	11,219.20	0.00			
CARDIOLOGY	533,488.55	0.00			
AMBULATORY SURGERY	1,677.50	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,993.80	0.00			
ORGAN ACQUISITION	0.00	1,020.50			
TREATMENT/OBSERV. RM	6,401.60	0.00			
			TOTAL ANCILLARY	9,453,880.50	134,032.35
			TOTAL ACCOMODATIONS	3,450,450.00	54,075.00
			TOTAL CHARGES	12,904,330.50	188,107.35

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:45:56  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	97,627.85	ADJUSTMENTS	0.00
COVERED CHARGES	95,812.65	CONTRACTUAL ALLOW	21,808.82
NON-COVERD CHARGES	1,815.20	TOTAL MEDICAID LIAB	74,003.83
		LESS: COB	74,003.83
		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	9		0	7,390.00		395.00
ROUTINE NURSERY	12		0	5,580.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	21		0	12,970.00		395.00
SPECIAL CARE SERVICES						
CCU	13		0	18,590.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	18,590.00		0.00
TOTAL ACCOMODATIONS	34		0	31,560.00		395.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,115.86	0.00	OTHER LAB	576.65	0.00
MED/SURG SUPPLY	4,699.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,853.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,108.20	0.00	OTHER THERAPEUTIC SVC	0.00	1,420.20
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	427.90	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	11,603.65	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,781.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,336.95	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,587.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	645.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	547.00	0.00	INJECTABLE DRUGS	8,321.39	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	257.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	631.10	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	525.90	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,252.65	1,420.20
			TOTAL ACCOMODATIONS	31,560.00	395.00
			TOTAL CHARGES	95,812.65	1,815.20

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: 09/24/2013  
Run Time: 18:45:58  
Page: 5

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,707,025.14	ADJUSTMENTS	657,889.89
COVERED CHARGES	11,622,295.73	CONTRACTUAL ALLOW	8,967,562.52
NON-COVERD CHARGES	1,084,729.41	TOTAL MEDICAID LIAB	2,654,733.21
		LESS: COB	5,848.61
		LESS: COPAYMENT	4,960.10
		REIMBURSEMENT	2,643,924.50
		ALL OTHER	2,361,179.48
		FEE SCHEDULE-LAB	225,222.54
		INJECTABLE DRUGS	57,522.48

TOTAL NUMBER OF CLAIMS 6,649

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	426,651.07	21,353.50	OTHER LAB	182,434.15	0.00
MED/SURG SUPPLY	375,409.32	35,057.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	106.15	EDUCATION & TRAINING	0.00	544.50
RADIOLOGY-DIAGNOSTIC	440,764.40	37,283.90	OTHER THERAPEUTIC SVC	0.00	492.90
CT SCAN	1,016,722.85	29,525.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,992.90	6,269.30	FEE SCHEDULE LAB	1,613,696.06	298,083.53
EKG/ECG	112,335.50	5,405.00	MRI SERVICES	105,752.45	12,429.70
IV THERAPY	289,481.00	29,872.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,620,221.55	213,538.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	45,401.40	175.30	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,398.90	7,621.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	667,512.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	188,795.25	15,094.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,352,838.04	52,472.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	287,219.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	517,677.06	69,591.58
RADIOLOGY THERAPEUTIC	247,882.05	1,188.35	HOME HEALTH SERVICES	0.00	69.70
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,269.75	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	904.25	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	39,600.55	1,266.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,787.10	47,210.70
LITHOTRIPSY	11,104.45	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	277,220.55	43,634.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,440.50	9,455.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	106,754.40	47,083.70			
AUDIOLOGY	1,291.55	1,069.60			
CARDIOLOGY	318,354.40	95,546.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,981.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	259,574.83	112.20			
			TOTAL ANCILLARY	11,622,295.73	1,084,729.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,622,295.73	1,084,729.41

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	355,772.63	ADJUSTMENTS	0.00
COVERED CHARGES	280,014.43	CONTRACTUAL ALLOW	77,967.55
NON-COVERD CHARGES	75,758.20	TOTAL MEDICAID LIAB	202,046.88
		LESS: COB	201,998.69
		LESS: COPAYMENT	48.19
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 175

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,063.91	115.75	OTHER LAB	5,196.70	0.00
MED/SURG SUPPLY	13,783.10	35.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,514.60	275.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,040.30	22,740.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,468.06	8,402.30
EKG/ECG	2,350.00	0.00	MRI SERVICES	8,374.00	2,113.65
IV THERAPY	5,850.95	182.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,849.00	29,056.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,759.80	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,116.00	189.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,873.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,015.55	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,791.05	2,567.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,524.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,808.34	1,241.50
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	241.10	16.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	422.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,174.25	5,201.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,117.00	1,181.80			
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	4,117.72	0.00			
			TOTAL ANCILLARY	280,014.43	75,758.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	280,014.43	75,758.20

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: 09/24/2013  
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WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	723,781.91	ADJUSTMENTS	3,348.26
COVERED CHARGES	701,323.96	CONTRACTUAL ALLOW	634,986.91
NON-COVERD CHARGES	22,457.95	TOTAL MEDICAID LIAB	66,337.05
		LESS: COB	34.35
		LESS: COPAYMENT	2,229.09
		REIMBURSEMENT	64,073.61
		TOTAL NUMBER OF CLAIMS	1,186



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,355.25	2,710.75	OTHER LAB	4,045.60	0.00
MED/SURG SUPPLY	6,456.30	190.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,299.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,460.95	1,051.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	116,124.15	12,376.45
EKG/ECG	9,517.50	0.00	MRI SERVICES	2,243.35	0.00
IV THERAPY	1,116.00	273.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,392.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,185.20	483.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	458,692.10	4,327.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,051.80	374.80
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	10,313.90	669.75			
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	1,321.60	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	1,748.06	0.00			
			TOTAL ANCILLARY	701,323.96	22,457.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	701,323.96	22,457.95

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: 09/24/2013  
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WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,970.85	ADJUSTMENTS	0.00
COVERED CHARGES	18,107.75	CONTRACTUAL ALLOW	8,683.35
NON-COVERD CHARGES	863.10	TOTAL MEDICAID LIAB	9,424.40
		LESS: COB	9,406.40
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 18

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131.25	60.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	380.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	377.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,051.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,630.50	434.45
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	422.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,143.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	667.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	301.60	368.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	766.55	0.00			
			TOTAL ANCILLARY	18,107.75	863.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,107.75	863.10

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	970,382.89	ADJUSTMENTS	49,806.50
COVERED CHARGES	832,677.34	CONTRACTUAL ALLOW	678,137.69
NON-COVERD CHARGES	137,705.55	TOTAL MEDICAID LIAB	154,539.65
		LESS: COB	0.00
		LESS: COPAYMENT	504.00
		REIMBURSEMENT	154,035.65

TOTAL NUMBER OF CLAIMS 31

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,066.27	201.50	OTHER LAB	941.25	0.00
MED/SURG SUPPLY	39,246.05	25,083.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	198.00
RADIOLOGY-DIAGNOSTIC	2,277.45	2,828.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,229.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,930.75	FEE SCHEDULE LAB	14,917.25	1,078.45
EKG/ECG	705.00	352.50	MRI SERVICES	0.00	0.00
IV THERAPY	25,806.40	5,887.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	220,016.70	631.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,184.20	70.15	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,768.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,402.95	601.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,985.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	122,157.64	10,995.75
RADIOLOGY THERAPEUTIC	295,009.85	11,064.60	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,630.30	58.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,254.00	73,184.90
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,982.55	866.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,020.50	804.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,866.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,607.35	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,467.88	0.00			
			TOTAL ANCILLARY	832,677.34	137,705.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	832,677.34	137,705.55

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/11	THROUGH	09/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:47:21  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER 000002076A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,882,249.51	ADJUSTMENTS	24,463.77
COVERED CHARGES	1,832,306.71	CONTRACTUAL ALLOW	1,179,953.33
NON-COVERD CHARGES	49,942.80	TOTAL MEDICAID LIAB	652,353.38
		LESS: COB	15,142.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	637,210.46

TOTAL NUMBER OF ADMISSIONS 103

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	495		0	225,500.00		46,050.00
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	495		0	225,500.00		46,050.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	495		0	225,500.00		46,050.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	624,154.22	0.00	OTHER LAB	13,435.90	0.00
MED/SURG SUPPLY	278,733.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	234,286.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,856.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	146,419.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,404.35	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,464.20	0.00	MRI SERVICES	11,642.95	0.00
IV THERAPY	597.05	0.00	PROFESSIONAL FEES	0.00	172.55
OPERATING ROOM	5,538.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,825.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,110.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,440.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,849.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,936.99	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,778.55	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	947.70	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,578.00
OTHER IMAGING SERVICE	5,319.35	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	25,252.35	2,142.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,857.70	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,383.90	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,570.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,606,806.71	3,892.80
			TOTAL ACCOMODATIONS	225,500.00	46,050.00
			TOTAL CHARGES	1,832,306.71	49,942.80



Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 09/24/2013  
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LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
620	2212174001484	02/12/12 - 02/29/12	06/25/12	0.00	1,578.00	0.00	0.00	0.00
TOTAL				0.00	1,578.00	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: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
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LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,423,419.58	ADJUSTMENTS	12,162.40
COVERED CHARGES	4,087,247.41	CONTRACTUAL ALLOW	3,142,499.80
NON-COVERD CHARGES	336,172.17	TOTAL MEDICAID LIAB	944,747.61
		LESS: COB	60.00
		LESS: COPAYMENT	2,304.00
		REIMBURSEMENT	942,383.61
		ALL OTHER	888,519.84
		FEE SCHEDULE-LAB	49,405.57
		INJECTABLE DRUGS	4,458.20

TOTAL NUMBER OF CLAIMS 1,713

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	263,784.13	2,879.25	OTHER LAB	17,413.75	0.00
MED/SURG SUPPLY	402,337.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	244.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	106,514.25	2,437.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	240,519.90	15,659.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,275.65	281.60	FEE SCHEDULE LAB	434,540.92	98,412.21
EKG/ECG	28,949.40	3,005.90	MRI SERVICES	33,928.95	0.00
IV THERAPY	55,147.40	18,084.05	PROFESSIONAL FEES	0.00	238.00
OPERATING ROOM	1,947,308.41	178,872.71	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,227.00	1,193.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	230,764.62	8,078.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	235,327.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,684.34	28.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,557.55	1,747.15	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	328.90	1,315.60	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,133.45
OTHER IMAGING SERVICE	9,964.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,124.00	2,260.50			
ONCOLOGY	162.00	0.00			
NUCLEAR MEDICINE	12,498.55	300.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,150.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,356.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,381.44	0.00			
			TOTAL ANCILLARY	4,087,247.41	336,172.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,087,247.41	336,172.17

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
30	2212172009968	06/01/12 - 06/01/12	06/25/12	0.00	236.80	0.00	0.00	0.00
3001	2212195002754	07/09/12 - 07/09/12	07/16/12	0.00	21.75	0.00	0.00	0.00
30	2212195003298	07/07/12 - 07/07/12	07/16/12	0.00	171.60	0.00	0.00	0.00
2710	2212201002449	07/17/12 - 07/17/12	07/23/12	0.00	451.35	0.00	0.00	0.00
30	2212272005864	09/26/12 - 09/26/12	10/01/12	0.00	21.75	0.00	0.00	0.00
30	2212326002821	11/05/12 - 11/06/12	11/26/12	0.00	53.90	0.00	0.00	0.00
30	2212347005714	11/25/12 - 11/26/12	12/17/12	0.00	176.30	0.00	0.00	0.00
TOTAL				0.00	1,133.45	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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,601.95	ADJUSTMENTS	0.00
COVERED CHARGES	9,861.55	CONTRACTUAL ALLOW	8,514.51
NON-COVERD CHARGES	740.40	TOTAL MEDICAID LIAB	1,347.04
		LESS: COB	1,344.04
		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

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	522.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,064.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,087.95	152.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,499.85	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,474.65	130.50
EKG/ECG	0.00	247.50	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	51.45	FREE STANDING CLINIC	127.05	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,035.70	158.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28.60	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,861.55	740.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,861.55	740.40

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: 09/24/2013  
Run Time: 18:48:00  
Page: 10

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,488.27	ADJUSTMENTS	0.00
COVERED CHARGES	61,417.22	CONTRACTUAL ALLOW	57,583.92
NON-COVERD CHARGES	3,071.05	TOTAL MEDICAID LIAB	3,833.30
		LESS: COB	0.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	3,653.30
		TOTAL NUMBER OF CLAIMS	77



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,816.47	44.60	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	647.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,014.80	172.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,593.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,166.40	2,332.05
EKG/ECG	1,732.50	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	51.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,693.85	522.25	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	265.80	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	434.50	0.00			
			TOTAL ANCILLARY	61,417.22	3,071.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,417.22	3,071.05

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: 09/24/2013  
Run Time: 18:48:02  
Page: 12

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	717.80	ADJUSTMENTS	0.00
COVERED CHARGES	717.80	CONTRACTUAL ALLOW	714.80
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:48:02  
 Page: 13

SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	312.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	391.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	717.80	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	717.80	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
Run Time: 18:48:03  
Page: 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	958,764.45	ADJUSTMENTS	28,472.46
COVERED CHARGES	957,153.00	CONTRACTUAL ALLOW	767,216.60
NON-COVERD CHARGES	1,611.45	TOTAL MEDICAID LIAB	189,936.40
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	189,825.40
		TOTAL NUMBER OF CLAIMS	40

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,346.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	263,754.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	654.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,550.55	1,611.45	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	640,021.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,792.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	957,153.00	1,611.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	957,153.00	1,611.45

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: 09/24/2013  
Run Time: 18:48:04  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:48:14  
 Page: 1

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	343,444.00	ADJUSTMENTS	0.00
COVERED CHARGES	324,174.00	CONTRACTUAL ALLOW	159,910.22
NON-COVERD CHARGES	19,270.00	TOTAL MEDICAID LIAB	164,263.78
		LESS: COB	4,630.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	159,633.46

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	183		0	65,880.00		15,340.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	183		0	65,880.00		15,340.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	35		0	41,950.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	35		0	41,950.00		0.00
TOTAL ACCOMODATIONS	218		0	107,830.00		15,340.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:48:14  
 Page: 2

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113,509.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,093.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,422.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,912.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,428.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,150.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,500.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,205.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,340.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,719.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	524.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,329.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,702.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	635.00	3,930.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	922.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,211.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,310.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,113.00	0.00			
			TOTAL ANCILLARY	216,344.00	3,930.00
			TOTAL ACCOMODATIONS	107,830.00	15,340.00
			TOTAL CHARGES	324,174.00	19,270.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:48:16  
Page: 3

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 05/01/11 THROUGH 04/30/12  
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: 09/24/2013  
Run Time: 18:48:17  
Page: 4

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	558,498.77	ADJUSTMENTS	13,210.12
COVERED CHARGES	476,322.47	CONTRACTUAL ALLOW	249,803.88
NON-COVERD CHARGES	82,176.30	TOTAL MEDICAID LIAB	226,518.59
		LESS: COB	545.78
		LESS: COPAYMENT	2,067.00
		REIMBURSEMENT	223,905.81
		ALL OTHER	199,742.86
		FEE SCHEDULE-LAB	23,046.15
		INJECTABLE DRUGS	1,116.80

TOTAL NUMBER OF CLAIMS 1,124

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 18:48:17  
 Page: 5

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,909.50	197.00	OTHER LAB	2,700.00	0.00
MED/SURG SUPPLY	20,948.00	327.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	199.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,753.00	1,459.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,774.00	11,077.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,290.00	185.00	FEE SCHEDULE LAB	118,682.00	29,510.30
EKG/ECG	9,885.00	0.00	MRI SERVICES	32,575.00	0.00
IV THERAPY	14,495.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,847.00	23,905.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,582.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,384.00	1,115.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,240.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,957.97	5,787.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,998.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	635.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,605.00	280.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	234.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,378.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	524.00	120.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,010.00	7,380.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,000.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,551.00	0.00			
			TOTAL ANCILLARY	476,322.47	82,176.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	476,322.47	82,176.30

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: 09/24/2013  
Run Time: 18:48:44  
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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 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,622.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,197.00	CONTRACTUAL ALLOW	3,221.53
NON-COVERD CHARGES	425.00	TOTAL MEDICAID LIAB	975.47
		LESS: COB	974.90
		LESS: COPAYMENT	0.57
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	231.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	120.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	493.00	124.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,513.00	301.00
EKG/ECG	210.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	250.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,380.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,197.00	425.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,197.00	425.00

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: 09/24/2013  
Run Time: 18:48:44  
Page: 8

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/11 THROUGH 04/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,973.00	ADJUSTMENTS	50.00
COVERED CHARGES	14,415.00	CONTRACTUAL ALLOW	9,865.00
NON-COVERD CHARGES	558.00	TOTAL MEDICAID LIAB	4,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	204.00
		REIMBURSEMENT	4,346.00
		TOTAL NUMBER OF CLAIMS	91

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 05/01/11 THROUGH 04/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	555.00	15.00	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	627.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,331.00	543.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	290.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,072.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	221.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	85.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	67.00	0.00			
			TOTAL ANCILLARY	14,415.00	558.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,415.00	558.00

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: 09/24/2013  
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Page: 10

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
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: 09/24/2013  
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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 05/01/11 THROUGH 04/30/12  
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: 09/24/2013  
Run Time: 18:48:47  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/11	THROUGH	04/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER 000002098A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,838,590.82	ADJUSTMENTS	134,976.20
COVERED CHARGES	7,450,167.15	CONTRACTUAL ALLOW	5,386,772.13
NON-COVERD CHARGES	388,423.67	TOTAL MEDICAID LIAB	2,063,395.02
		LESS: COB	22,991.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,040,403.91

TOTAL NUMBER OF ADMISSIONS 303

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	421		361	169,887.52		285,060.16
ROUTINE NURSERY	39		0	11,840.40		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	460		361	181,727.92		285,060.16
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	199		0	211,544.96		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	199		0	211,544.96		0.00
TOTAL ACCOMODATIONS	659		361	393,272.88		285,060.16

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,252,006.48	0.00	OTHER LAB	42,307.50	0.00
MED/SURG SUPPLY	576,377.18	412.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,240,642.79	0.00	EDUCATION & TRAINING	471.60	0.00
RADIOLOGY-DIAGNOSTIC	227,704.93	16,225.91	OTHER THERAPEUTIC SVC	0.00	35,354.01
CT SCAN	744,621.29	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	69,765.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	89,475.40	0.00	MRI SERVICES	70,819.95	0.00
IV THERAPY	833.68	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	592,636.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,374.59	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	456,242.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	267,227.53	0.00	AMBULANCE	0.00	0.00
GI SERVICES	78,481.80	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	521,120.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	63,827.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,743.71	0.00	INJECTABLE DRUGS	694.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,034.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,529.98	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60.15	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	349,847.92	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	12,515.66
OTHER IMAGING SERVICE	84,632.83	10,524.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,524.54	17,120.23			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,255.20	11,210.40			
AUDIOLOGY	726.00	0.00			
CARDIOLOGY	127,366.40	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	9,540.84	0.00			
			TOTAL ANCILLARY	7,056,894.27	103,363.51
			TOTAL ACCOMODATIONS	393,272.88	285,060.16
			TOTAL CHARGES	7,450,167.15	388,423.67

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: 09/24/2013  
Run Time: 18:48:53  
Page: 3

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5912033002198	01/09/12 - 01/12/12	02/06/12	0.00	3,862.86	0.00	0.00	0.00
615	2213119009256	12/08/12 - 12/31/12	05/06/13	0.00	8,652.80	0.00	0.00	0.00
TOTAL				0.00	12,515.66	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: 09/24/2013  
 Run Time: 18:49:08  
 Page: 4

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,718.95	ADJUSTMENTS	0.00
COVERED CHARGES	27,804.39	CONTRACTUAL ALLOW	18,839.66
NON-COVERD CHARGES	2,914.56	TOTAL MEDICAID LIAB	8,964.73
		LESS: COB	8,964.73
		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		4	0.00		2,914.56
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	0		4	0.00		2,914.56
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	0		4	0.00		2,914.56

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,230.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	990.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,768.54	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	655.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,696.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	360.01	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15.99	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,744.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,584.37	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,909.60	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	848.59	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,804.39	0.00
			TOTAL ACCOMODATIONS	0.00	2,914.56
			TOTAL CHARGES	27,804.39	2,914.56

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 18:49:09  
Page: 6

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,965,333.57	ADJUSTMENTS	995,712.86
COVERED CHARGES	13,707,443.77	CONTRACTUAL ALLOW	10,912,643.37
NON-COVERD CHARGES	1,257,889.80	TOTAL MEDICAID LIAB	2,794,800.40
		LESS: COB	11,107.80
		LESS: COPAYMENT	3,960.00
		REIMBURSEMENT	2,779,732.60
		ALL OTHER	2,680,353.87
		FEE SCHEDULE-LAB	87,858.18
		INJECTABLE DRUGS	11,520.55

TOTAL NUMBER OF CLAIMS 3,854



SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,498.42	175,971.43	OTHER LAB	112,970.66	5,966.89
MED/SURG SUPPLY	352,980.79	12,035.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	6,241.59	EDUCATION & TRAINING	0.00	104.80
RADIOLOGY-DIAGNOSTIC	993,020.63	27,303.94	OTHER THERAPEUTIC SVC	0.00	15,589.19
CT SCAN	2,260,541.93	213,630.44	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,661.00	3,746.80	FEE SCHEDULE LAB	1,373,071.99	371,352.95
EKG/ECG	129,590.79	4,242.98	MRI SERVICES	532,193.73	21,168.46
IV THERAPY	17,972.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,156,584.29	80,638.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,684.26	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76,963.40	20,997.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	684,153.02	19,434.72	AMBULANCE	0.00	0.00
GI SERVICES	637,307.37	31,930.63	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,946,643.23	17,472.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	304,007.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	280,873.36	150,965.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,688.00	7,662.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,620.04	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	58.55	3,661.92	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70,615.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	290,445.25	29,873.77			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,493.56	861.58			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	186,943.25	30,760.74			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	67,771.58	2,376.09			
AMBULATORY SURGERY	3,384.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,080.04	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	185,244.80	182.48			
			TOTAL ANCILLARY	13,707,443.77	1,255,793.64
			TOTAL ACCOMODATIONS	0.00	2,096.16
			TOTAL CHARGES	13,707,443.77	1,257,889.80

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 18:50:32  
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	136,494.42	ADJUSTMENTS	0.00
COVERED CHARGES	103,889.15	CONTRACTUAL ALLOW	35,551.64
NON-COVERD CHARGES	32,605.27	TOTAL MEDICAID LIAB	68,337.51
		LESS: COB	68,319.77
		LESS: COPAYMENT	17.74
		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

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	533.94	1,223.33	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,518.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,467.02	519.77	OTHER THERAPEUTIC SVC	0.00	285.74
CT SCAN	0.00	19,289.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,964.36	2,679.02
EKG/ECG	1,440.04	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,677.68	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	937.20	333.36	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	3,824.43	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,871.10	346.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,050.85	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,823.02	1,252.99
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,326.46	2,851.29			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,139.52	0.00			
			TOTAL ANCILLARY	103,889.15	32,605.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	103,889.15	32,605.27

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 18:50:34  
Page: 10

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,204,942.02	ADJUSTMENTS	3,180.45
COVERED CHARGES	1,172,846.87	CONTRACTUAL ALLOW	1,136,429.94
NON-COVERD CHARGES	32,095.15	TOTAL MEDICAID LIAB	36,416.93
		LESS: COB	0.00
		LESS: COPAYMENT	1,098.02
		REIMBURSEMENT	35,318.91
		TOTAL NUMBER OF CLAIMS	651

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	159.15	11,688.38	OTHER LAB	1,916.33	0.00
MED/SURG SUPPLY	18,632.90	130.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,699.21	0.00	OTHER THERAPEUTIC SVC	0.00	84.39
CT SCAN	80,856.31	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83,666.95	15,348.24
EKG/ECG	8,730.26	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,048.10	1,674.96	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	886,499.66	1.23	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,772.56	3,044.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	122.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,035.22	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,830.22	0.00			
			TOTAL ANCILLARY	1,172,846.87	32,095.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,172,846.87	32,095.15

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:50:48  
Page: 12

SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,479.40	ADJUSTMENTS	0.00
COVERED CHARGES	29,909.04	CONTRACTUAL ALLOW	26,462.67
NON-COVERD CHARGES	1,570.36	TOTAL MEDICAID LIAB	3,446.37
		LESS: COB	3,431.36
		LESS: COPAYMENT	15.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	276.67	OTHER LAB	798.99	0.00
MED/SURG SUPPLY	1,463.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,566.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,736.80	1,099.89
EKG/ECG	1,080.03	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	626.26	184.80	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	17,403.64	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2.46	9.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,230.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	29,909.04	1,570.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,909.04	1,570.36

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:50:49  
Page: 14

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	398,947.22	ADJUSTMENTS	45,995.67
COVERED CHARGES	348,703.12	CONTRACTUAL ALLOW	292,431.19
NON-COVERD CHARGES	50,244.10	TOTAL MEDICAID LIAB	56,271.93
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	56,214.93
		TOTAL NUMBER OF CLAIMS	11



SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER  
 316 N BROAD ST  
 WINDER,GA 30680-2150

PROVIDER NUMBER  
 000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	12,081.93	OTHER LAB	1,109.62	0.00
MED/SURG SUPPLY	8,858.01	1,838.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	52.40
RADIOLOGY-DIAGNOSTIC	3,821.00	0.00	OTHER THERAPEUTIC SVC	0.00	191.32
CT SCAN	3,712.59	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,051.91	FEE SCHEDULE LAB	11,911.23	6,925.88
EKG/ECG	3,240.09	720.02	MRI SERVICES	12,979.20	4,326.40
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	112,546.92	7,229.78	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,118.16	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,519.29	1,738.11	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,662.40	84.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,023.45	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,660.27	14,003.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	98,010.17	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,530.72	0.00			
			TOTAL ANCILLARY	348,703.12	50,244.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	348,703.12	50,244.10

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: 09/24/2013  
Run Time: 18:50:51  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:50:58  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER  
 807 S ISABELLA ST  
 SYLVESTER,GA 31791-7554

PROVIDER NUMBER 000002109A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	401,122.00	ADJUSTMENTS	4,481.79
COVERED CHARGES	398,587.00	CONTRACTUAL ALLOW	184,706.31
NON-COVERD CHARGES	2,535.00	TOTAL MEDICAID LIAB	213,880.69
		LESS: COB	1,208.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	212,672.59

TOTAL NUMBER OF ADMISSIONS 54

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	160		0	79,975.00		2,535.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	160		0	79,975.00		2,535.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	160		0	79,975.00		2,535.00

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,936.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	96,232.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	71,385.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,320.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,039.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,193.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,621.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,512.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,644.00	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	853.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	166.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	243.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	500.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,166.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	802.00	0.00			
			TOTAL ANCILLARY	318,612.00	0.00
			TOTAL ACCOMODATIONS	79,975.00	2,535.00
			TOTAL CHARGES	398,587.00	2,535.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:50:59  
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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	08/01/11	THROUGH	07/31/12
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: 09/24/2013  
Run Time: 18:51:00  
Page: 4

PHOEBE WORTH MEDICAL CENTER  
807 S ISABELLA ST  
SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,128,866.78	ADJUSTMENTS	17,827.35
COVERED CHARGES	1,028,319.28	CONTRACTUAL ALLOW	716,784.66
NON-COVERD CHARGES	100,547.50	TOTAL MEDICAID LIAB	311,534.62
		LESS: COB	554.66
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	310,244.96
		ALL OTHER	284,345.72
		FEE SCHEDULE-LAB	22,247.63
		INJECTABLE DRUGS	3,651.61
		TOTAL NUMBER OF CLAIMS	1,116

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 18:51:00  
 Page: 5

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,305.00	4,771.50	OTHER LAB	3,671.00	3,600.00
MED/SURG SUPPLY	53,836.72	857.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,383.00	1,829.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	141,334.00	23,490.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,063.00	FEE SCHEDULE LAB	236,180.33	53,796.00
EKG/ECG	18,082.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,621.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,152.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	356,846.00	1,678.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,105.23	5,457.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	243.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	86.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	321.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,517.00	3,599.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,108.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,852.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,956.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,127.00	0.00			
			TOTAL ANCILLARY	1,028,319.28	100,547.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,028,319.28	100,547.50

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: 09/24/2013  
Run Time: 18:51:15  
Page: 6

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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,465.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,851.00	CONTRACTUAL ALLOW	3,297.10
NON-COVERD CHARGES	614.00	TOTAL MEDICAID LIAB	7,553.90
		LESS: COB	7,553.90
		LESS: COPAYMENT	0.00
		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

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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	811.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	747.00	33.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	466.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,493.00	155.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	500.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	235.00	426.00			
			TOTAL ANCILLARY	10,851.00	614.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,851.00	614.00

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: 09/24/2013  
Run Time: 18:51:15  
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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 08/01/11 THROUGH 07/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	142,119.88	ADJUSTMENTS	47.00
COVERED CHARGES	134,063.88	CONTRACTUAL ALLOW	123,513.88
NON-COVERD CHARGES	8,056.00	TOTAL MEDICAID LIAB	10,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	360.00
		REIMBURSEMENT	10,190.00
		TOTAL NUMBER OF CLAIMS	211

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:51:15  
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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 08/01/11 THROUGH 07/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,647.40	379.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,349.48	152.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,323.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,195.00	1,400.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,899.00	1,645.00
EKG/ECG	2,130.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	88,968.00	1,261.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,302.00	1,873.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,599.00	1,346.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	582.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	134,063.88	8,056.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	134,063.88	8,056.00

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: 09/24/2013  
Run Time: 18:51:18  
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	08/01/11	THROUGH	07/31/12
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: 09/24/2013  
Run Time: 18:51:18  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER  
807 S ISABELLA ST  
SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
000002109A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/11	THROUGH	07/31/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER  
807 S ISABELLA ST  
SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
000002109A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/11	THROUGH	07/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER 000020677A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,105,751.27	ADJUSTMENTS	64,188.32
COVERED CHARGES	9,964,502.79	CONTRACTUAL ALLOW	7,324,636.50
NON-COVERD CHARGES	141,248.48	TOTAL MEDICAID LIAB	2,639,866.29
		LESS: COB	31,288.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,608,577.39

TOTAL NUMBER OF ADMISSIONS 365

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	637		41	295,103.20		19,359.00
ROUTINE NURSERY	49		0	12,936.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	686		41	308,039.20		19,359.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	704		0	675,865.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	704		0	675,865.00		0.00
TOTAL ACCOMODATIONS	1,390		41	983,904.20		19,359.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,521,175.49	0.00	OTHER LAB	98,615.19	0.00
MED/SURG SUPPLY	316,804.44	424.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,742,865.11	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	324,509.54	7,584.06	OTHER THERAPEUTIC SVC	0.00	7,386.55
CT SCAN	782,176.81	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,978.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	161,726.15	0.00	MRI SERVICES	83,329.16	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	714,394.03	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,025.37	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	290,152.93	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	738,551.79	0.00	AMBULANCE	0.00	0.00
GI SERVICES	67,035.34	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	726,713.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	206,462.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	21,789.89	0.00	INJECTABLE DRUGS	8,226.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	30,586.95	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,290.55	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30.42	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	246,116.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53,164.03
OTHER IMAGING SERVICE	85,038.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63,796.30	33,329.91			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	154,263.19	19,701.96			
AUDIOLOGY	3,582.05	298.88			
CARDIOLOGY	466,771.81	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,583.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,007.21	0.00			
			TOTAL ANCILLARY	8,980,598.59	121,889.48
			TOTAL ACCOMODATIONS	983,904.20	19,359.00
			TOTAL CHARGES	9,964,502.79	141,248.48



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: 09/24/2013  
 Run Time: 18:51:24  
 Page: 3

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2011294007201	10/06/11 - 10/06/11	10/24/11	0.00	3,251.85	0.00	0.00	0.00
615	2011340107429	11/26/11 - 11/26/11	12/12/11	0.00	4,398.69	0.00	0.00	0.00
615	2011356030856	12/15/11 - 12/15/11	12/26/11	0.00	8,024.54	0.00	0.00	0.00
30	2212023007199	12/28/11 - 01/07/12	01/30/12	0.00	438.90	0.00	0.00	0.00
615	1012044010163	01/05/12 - 01/05/12	02/20/12	0.00	4,398.69	0.00	0.00	0.00
615	9112052010859	01/05/12 - 01/05/12	03/19/12	0.00	4,398.69	0.00	1,779.89	0.00
615	2212130008219	04/09/12 - 04/13/12	05/14/12	0.00	9,426.27	0.00	0.00	0.00
615	2012213017552	07/17/12 - 07/19/12	08/06/12	0.00	4,706.60	0.00	0.00	0.00
615	2012252003767	08/30/12 - 09/05/12	09/17/12	0.00	4,706.60	0.00	0.00	0.00
615	2212296005213	08/26/12 - 08/29/12	10/29/12	0.00	4,706.60	0.00	0.00	0.00
615	2212297013199	07/16/12 - 07/17/12	10/29/12	0.00	4,706.60	0.00	0.00	0.00
TOTAL				0.00	53,164.03	0.00	1,779.89	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: 09/24/2013  
Run Time: 18:51:33  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
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: 09/24/2013  
Run Time: 18:51:34  
Page: 5

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,548,318.33	ADJUSTMENTS	436,457.07
COVERED CHARGES	8,522,028.02	CONTRACTUAL ALLOW	6,790,971.06
NON-COVERD CHARGES	1,026,290.31	TOTAL MEDICAID LIAB	1,731,056.96
		LESS: COB	893.70
		LESS: COPAYMENT	2,739.40
		REIMBURSEMENT	1,727,423.86
		ALL OTHER	1,639,408.87
		FEE SCHEDULE-LAB	77,203.28
		INJECTABLE DRUGS	10,811.71

TOTAL NUMBER OF CLAIMS 3,348

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,030.34	183,228.51	OTHER LAB	312,336.46	9,829.48
MED/SURG SUPPLY	120,927.94	27,864.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	429,929.15	12,334.82	OTHER THERAPEUTIC SVC	0.00	33,426.79
CT SCAN	1,081,667.60	257,897.47	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	364.25	FEE SCHEDULE LAB	988,358.14	195,608.99
EKG/ECG	135,068.08	1,273.50	MRI SERVICES	336,793.69	9,404.79
IV THERAPY	21,844.56	273.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	345,089.10	95,091.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,101.82	6,478.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	431,030.20	775.93	AMBULANCE	0.00	0.00
GI SERVICES	161,668.03	25,106.92	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,968,015.33	7,023.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	341,686.59	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	414.34	INJECTABLE DRUGS	190,118.09	99,118.97
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	998.66	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	591.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,175.91	32,306.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	257,013.36	12,508.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,725.16	2,586.36			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	121,267.18	10,374.93			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	147,949.82	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,822.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	83,409.22	0.00			
			TOTAL ANCILLARY	8,522,028.02	1,024,881.95
			TOTAL ACCOMODATIONS	0.00	1,408.36
			TOTAL CHARGES	8,522,028.02	1,026,290.31

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: 09/24/2013  
Run Time: 18:52:30  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,694.63	ADJUSTMENTS	0.00
COVERED CHARGES	17,912.86	CONTRACTUAL ALLOW	11,292.47
NON-COVERD CHARGES	3,781.77	TOTAL MEDICAID LIAB	6,620.39
		LESS: COB	6,614.96
		LESS: COPAYMENT	5.43
		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

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	181.14	OTHER LAB	952.14	0.00
MED/SURG SUPPLY	50.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	906.53	0.00	OTHER THERAPEUTIC SVC	0.00	101.29
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,781.47	20.32
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	374.78	290.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,184.16	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,263.42	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	336.78	1,004.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	247.10	0.00			
			TOTAL ANCILLARY	17,912.86	3,781.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,912.86	3,781.77

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 18:52:31  
Page: 9

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	817,162.53	ADJUSTMENTS	2,753.94
COVERED CHARGES	752,461.46	CONTRACTUAL ALLOW	716,659.87
NON-COVERD CHARGES	64,701.07	TOTAL MEDICAID LIAB	35,801.59
		LESS: COB	0.00
		LESS: COPAYMENT	1,119.04
		REIMBURSEMENT	34,682.55
		TOTAL NUMBER OF CLAIMS	640

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,049.71	8,976.47	OTHER LAB	4,980.58	4,833.02
MED/SURG SUPPLY	793.15	361.58	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,657.31	0.00	OTHER THERAPEUTIC SVC	0.00	777.00
CT SCAN	25,638.31	28,415.69	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	101,796.80	16,888.20
EKG/ECG	17,145.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,608.57	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,269.85	499.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,215.68	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	537,405.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,766.34	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,194.55	3,949.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,441.84	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	497.12	0.00			
			TOTAL ANCILLARY	752,461.46	64,701.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	752,461.46	64,701.07



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,617.17	ADJUSTMENTS	0.00
COVERED CHARGES	8,317.88	CONTRACTUAL ALLOW	8,167.18
NON-COVERD CHARGES	299.29	TOTAL MEDICAID LIAB	150.70
		LESS: COB	147.70
		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: 09/24/2013  
 Run Time: 18:52:39  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	1,890.05	237.72
EKG/ECG	443.86	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,977.43	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	6.54	61.57
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,317.88	299.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,317.88	299.29

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	950,216.98	ADJUSTMENTS	44,227.68
COVERED CHARGES	858,757.87	CONTRACTUAL ALLOW	745,608.91
NON-COVERD CHARGES	91,459.11	TOTAL MEDICAID LIAB	113,148.96
		LESS: COB	0.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	113,037.96
		TOTAL NUMBER OF CLAIMS	23

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	607.55	5,660.10	OTHER LAB	1,981.10	2,847.81
MED/SURG SUPPLY	58,847.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	61.43	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,752.62	535.43	OTHER THERAPEUTIC SVC	0.00	1,097.44
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,383.17	1,155.99
EKG/ECG	1,331.58	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,223.12	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	383,059.48	65,122.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,456.74	352.62	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	198,338.08	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,561.33	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,400.29	13,282.41
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,995.30	0.00
LITHOTRIPSY	67,459.84	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	346.04	1,343.60			
CARDIOLOGY	813.01	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,200.84	0.00			
			TOTAL ANCILLARY	858,757.87	91,459.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	858,757.87	91,459.11

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/11 THROUGH 09/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,155.35	ADJUSTMENTS	0.00
COVERED CHARGES	22,425.67	CONTRACTUAL ALLOW	-9,026.23
NON-COVERD CHARGES	17,729.68	TOTAL MEDICAID LIAB	31,451.90
		LESS: COB	31,451.90
		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: 09/24/2013  
 Run Time: 18:52:42  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/11 THROUGH 09/30/12  
 ADMISSION DATES 00/00/00 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	1,627.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	15,612.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,742.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,519.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	2,117.67
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	12,536.37	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,425.67	17,729.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,425.67	17,729.68

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER 000081232A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,470,788.13	ADJUSTMENTS	61,185.99
COVERED CHARGES	2,440,031.53	CONTRACTUAL ALLOW	1,534,349.63
NON-COVERD CHARGES	30,756.60	TOTAL MEDICAID LIAB	905,681.90
		LESS: COB	1,778.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	903,903.26

TOTAL NUMBER OF ADMISSIONS 116

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	307		0	200,822.28		26,844.00
ROUTINE NURSERY	16		0	10,640.00		711.60
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	323		0	211,462.28		27,555.60
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	114		0	130,530.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	114		0	130,530.00		0.00
TOTAL ACCOMODATIONS	437		0	341,992.28		27,555.60

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	725,196.09	0.00	OTHER LAB	13,556.66	0.00
MED/SURG SUPPLY	129,601.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	373,822.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,253.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	152,093.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,727.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	17,226.00	0.00	MRI SERVICES	3,835.00	0.00
IV THERAPY	1,015.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,754.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,950.87	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	154,055.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,787.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146,358.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,371.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,534.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	543.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	67,226.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	108.00
OTHER IMAGING SERVICE	13,393.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,591.00	1,195.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,721.00	1,898.00			
AUDIOLOGY	1,838.86	0.00			
CARDIOLOGY	30,245.00	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	4,346.00	0.00			
			TOTAL ANCILLARY	2,098,039.25	3,201.00
			TOTAL ACCOMODATIONS	341,992.28	27,555.60
			TOTAL CHARGES	2,440,031.53	30,756.60



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: 09/24/2013  
Run Time: 18:52:49  
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CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3641	2211331000619	09/21/11 - 09/28/11	12/05/11	0.00	108.00	0.00	0.00	0.00
TOTAL				0.00	108.00	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: 09/24/2013  
Run Time: 18:52:52  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 18:52:52  
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CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,053,891.37	ADJUSTMENTS	18,167.15
COVERED CHARGES	1,766,332.24	CONTRACTUAL ALLOW	1,425,609.05
NON-COVERD CHARGES	287,559.13	TOTAL MEDICAID LIAB	340,723.19
		LESS: COB	4,063.81
		LESS: COPAYMENT	1,404.00
		REIMBURSEMENT	335,255.38
		ALL OTHER	307,721.27
		FEE SCHEDULE-LAB	27,485.75
		INJECTABLE DRUGS	48.36
		TOTAL NUMBER OF CLAIMS	1,258

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,903.87	104,811.00	OTHER LAB	11,747.88	2,586.00
MED/SURG SUPPLY	133,261.69	2,610.82	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	984.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110,763.00	3,348.00	OTHER THERAPEUTIC SVC	0.00	5,318.00
CT SCAN	195,462.00	8,260.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	272.28	171.00	FEE SCHEDULE LAB	365,860.00	59,600.00
EKG/ECG	20,013.00	0.00	MRI SERVICES	37,365.00	0.00
IV THERAPY	21,621.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	121,955.00	47,309.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	266.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,412.00	812.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	95,403.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	382,229.00	12,878.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,832.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,104.00	20,821.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,872.00	1,173.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	10,649.00	0.00	IMPL DEV CHARGE PATIENTS	23,824.02	4,000.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	101.00
OTHER IMAGING SERVICE	109,110.00	4,399.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	774.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,237.00	4,572.00			
AUDIOLOGY	0.00	251.31			
CARDIOLOGY	13,696.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,012.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,687.00	3,554.00			
			TOTAL ANCILLARY	1,766,332.24	287,559.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,766,332.24	287,559.13

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: 09/24/2013  
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CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8224	2211249012873	07/14/11 - 07/14/11	09/12/11	0.00	101.00	0.00	0.00	0.00
TOTAL				0.00	101.00	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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,998.61	ADJUSTMENTS	0.00
COVERED CHARGES	25,423.61	CONTRACTUAL ALLOW	15,266.96
NON-COVERD CHARGES	6,575.00	TOTAL MEDICAID LIAB	10,156.65
		LESS: COB	10,153.65
		LESS: COPAYMENT	3.00
		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

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,885.00	0.00	OTHER LAB	829.61	0.00
MED/SURG SUPPLY	557.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,398.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,741.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,682.00	1,447.00
EKG/ECG	792.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,551.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,646.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,905.00	1,251.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,066.00	1,968.00			
			TOTAL ANCILLARY	25,423.61	6,575.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,423.61	6,575.00

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: 09/24/2013  
Run Time: 18:53:09  
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CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	171,491.11	ADJUSTMENTS	382.58
COVERED CHARGES	150,617.50	CONTRACTUAL ALLOW	141,722.86
NON-COVERD CHARGES	20,873.61	TOTAL MEDICAID LIAB	8,894.64
		LESS: COB	0.00
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	8,657.64
		TOTAL NUMBER OF CLAIMS	162



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,030.00	10,886.61	OTHER LAB	0.00	431.00
MED/SURG SUPPLY	3,637.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,195.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,690.00	5,241.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	37,286.50	1,413.00
EKG/ECG	990.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,578.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,102.00	316.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	71,424.00	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	0.00	1,478.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,310.00	772.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	387.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	988.00	0.00			
			TOTAL ANCILLARY	150,617.50	20,873.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	150,617.50	20,873.61

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,363.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,345.00	CONTRACTUAL ALLOW	628.60
NON-COVERD CHARGES	18.00	TOTAL MEDICAID LIAB	716.40
		LESS: COB	716.40
		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: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83.00	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	528.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,345.00	18.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,345.00	18.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:53:18  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,765,090.71	ADJUSTMENTS	141,080.57
COVERED CHARGES	3,672,844.45	CONTRACTUAL ALLOW	2,842,361.64
NON-COVERD CHARGES	92,246.26	TOTAL MEDICAID LIAB	830,482.81
		LESS: COB	5,419.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	825,063.70

TOTAL NUMBER OF ADMISSIONS 239

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	212		85	145,642.13		75,830.18
ROUTINE NURSERY	172		0	94,388.28		4,762.97
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	384		85	240,030.41		80,593.15
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	62		0	66,069.45		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	62		0	66,069.45		0.00
TOTAL ACCOMODATIONS	446		85	306,099.86		80,593.15

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	548,246.37	0.00	OTHER LAB	2,600.78	0.00
MED/SURG SUPPLY	99,139.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	624,730.73	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,482.34	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,132.06	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,189.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,366.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,653.99	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	412,340.23	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	354,030.48	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	96,718.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	69,907.19	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,729.97	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	124,648.31	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,029.47	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,304.16	0.00	INJECTABLE DRUGS	691,570.43	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,169.30	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	63,984.15	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,538.56	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	55,636.14	9,673.67			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,607.70	1,979.44			
AUDIOLOGY	900.00	0.00			
CARDIOLOGY	4,806.28	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,281.13	0.00			
			TOTAL ANCILLARY	3,366,744.59	11,653.11
			TOTAL ACCOMODATIONS	306,099.86	80,593.15
			TOTAL CHARGES	3,672,844.45	92,246.26

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,028.76	ADJUSTMENTS	0.00
COVERED CHARGES	12,899.37	CONTRACTUAL ALLOW	9,008.93
NON-COVERD CHARGES	129.39	TOTAL MEDICAID LIAB	3,890.44
		LESS: COB	3,890.44
		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	3		0	2,156.49		129.39
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	2,156.49		129.39
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	2,156.49		129.39



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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,599.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	856.86	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	4,456.06	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,830.12	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,742.88	0.00
			TOTAL ACCOMODATIONS	2,156.49	129.39
			TOTAL CHARGES	12,899.37	129.39

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 18:53:25  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,709,371.75	ADJUSTMENTS	263,471.56
COVERED CHARGES	3,371,459.96	CONTRACTUAL ALLOW	2,803,725.86
NON-COVERD CHARGES	337,911.79	TOTAL MEDICAID LIAB	567,734.10
		LESS: COB	3,704.63
		LESS: COPAYMENT	1,386.00
		REIMBURSEMENT	562,643.47
		ALL OTHER	508,072.96
		FEE SCHEDULE-LAB	30,013.28
		INJECTABLE DRUGS	24,557.23

TOTAL NUMBER OF CLAIMS 1,293

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	173,289.65	8,100.17	OTHER LAB	125,459.85	3,195.85
MED/SURG SUPPLY	13,410.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	123.48	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132,638.18	1,757.39	OTHER THERAPEUTIC SVC	0.00	688.80
CT SCAN	417,705.27	9,618.67	SPECIAL CHARGES	2,589.77	0.00
PHYSICAL THERAPY	25,426.70	5,873.75	FEE SCHEDULE LAB	738,439.30	103,522.23
EKG/ECG	45,182.49	604.18	MRI SERVICES	52,190.90	2,745.16
IV THERAPY	11,228.34	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	236,699.17	23,668.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,712.91	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,327.97	558.28	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	62,221.81	0.00	AMBULANCE	0.00	0.00
GI SERVICES	54,435.51	2,368.17	CAST ROOM	0.00	0.00
EMERGENCY ROOM	587,430.00	39,382.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,352.17	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	335,293.27	106,848.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,282.05	971.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	857.02	404.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,080.05	633.09	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	7,401.83
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,745.16
OTHER IMAGING SERVICE	56,877.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,430.83	3,190.77			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	84,904.39	8,373.18			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	73,187.43	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,756.07	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,051.17	5,135.74			
			TOTAL ANCILLARY	3,371,459.96	337,911.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,371,459.96	337,911.79

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 18:53:25  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012326075161	11/17/12 - 11/17/12	11/26/12	0.00	2,745.16	0.00	0.00	0.00
TOTAL				0.00	2,745.16	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: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,678.89	ADJUSTMENTS	0.00
COVERED CHARGES	38,132.23	CONTRACTUAL ALLOW	22,423.20
NON-COVERD CHARGES	20,546.66	TOTAL MEDICAID LIAB	15,709.03
		LESS: COB	15,709.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,876.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,149.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,840.63	1,840.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,125.74	590.83
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	11,242.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,863.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,101.65	171.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,911.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	2,552.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,812.93	4,148.86			
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	417.89	0.00			
			TOTAL ANCILLARY	38,132.23	20,546.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,132.23	20,546.66

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	300,676.07	ADJUSTMENTS	1,838.93
COVERED CHARGES	282,380.33	CONTRACTUAL ALLOW	272,143.33
NON-COVERD CHARGES	18,295.74	TOTAL MEDICAID LIAB	10,237.00
		LESS: COB	0.00
		LESS: COPAYMENT	303.03
		REIMBURSEMENT	9,933.97
		TOTAL NUMBER OF CLAIMS	183

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP  
 2855 OLD HIGHWAY 5  
 BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
 000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,607.55	810.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,805.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,360.14	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,350.36	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	64,776.08	10,884.06
EKG/ECG	4,155.16	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,815.16	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	279.14	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,569.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	110,175.96	2,003.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,944.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,905.55	3,559.18
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	189.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,244.00	1,038.93			
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	202.86	0.00			
			TOTAL ANCILLARY	282,380.33	18,295.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	282,380.33	18,295.74



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP  
2855 OLD HIGHWAY 5  
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	656.30	ADJUSTMENTS	0.00
COVERED CHARGES	656.30	CONTRACTUAL ALLOW	150.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	506.30
		LESS: COB	506.30
		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: 09/24/2013  
 Run Time: 18:53:50  
 Page: 13

SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP  
 2855 OLD HIGHWAY 5  
 BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
 000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 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	115.76	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	540.54	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	656.30	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	656.30	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP  
2855 OLD HIGHWAY 5  
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	626,482.96	ADJUSTMENTS	82,806.20
COVERED CHARGES	595,618.31	CONTRACTUAL ALLOW	507,893.51
NON-COVERD CHARGES	30,864.65	TOTAL MEDICAID LIAB	87,724.80
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	87,676.80
		TOTAL NUMBER OF CLAIMS	18

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,514.55	1,624.26	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,015.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,452.29	68.14
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,686.22	499.73	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	367,492.34	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	373.72	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,280.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	501.06	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,581.22	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,573.83	14,723.08
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	2,525.44	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	13,949.44
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,621.27	0.00			
			TOTAL ANCILLARY	595,618.31	30,864.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	595,618.31	30,864.65

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER 000148233A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,114,397.25	ADJUSTMENTS	527,463.68
COVERED CHARGES	10,034,465.58	CONTRACTUAL ALLOW	7,269,721.76
NON-COVERD CHARGES	79,931.67	TOTAL MEDICAID LIAB	2,764,743.82
		LESS: COB	19,508.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,745,235.27

TOTAL NUMBER OF ADMISSIONS 380

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,238		0	613,354.00		12,251.00
ROUTINE NURSERY	103		0	40,065.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,341		0	653,419.00		12,251.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	513		0	438,860.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	513		0	438,860.00		0.00
TOTAL ACCOMODATIONS	1,854		0	1,092,279.00		12,251.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,304,915.70	12.00	OTHER LAB	43,034.00	0.00
MED/SURG SUPPLY	694,287.80	12,878.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,618,218.74	2,821.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,222.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	379,311.00	17,910.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,268.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	40,481.00	0.00	MRI SERVICES	116,239.00	0.00
IV THERAPY	45,936.00	1,380.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	799,784.43	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	111,832.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	343,970.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	150,162.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	55,515.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	291,898.00	309.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,411.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,306.30	0.00	INJECTABLE DRUGS	2,165,754.70	3,937.55
RADIOLOGY THERAPEUTIC	80,747.60	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,711.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,159.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,144.00	10,880.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	483.00	488.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	58,943.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	49,547.49	5,538.27			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	64,474.60	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	64,187.75	11,526.75			
AUDIOLOGY	11,250.00	0.00			
CARDIOLOGY	134,108.45	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,406.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,477.00	0.00			
			TOTAL ANCILLARY	8,942,186.58	67,680.67
			TOTAL ACCOMODATIONS	1,092,279.00	12,251.00
			TOTAL CHARGES	10,034,465.58	79,931.67

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,970.20	ADJUSTMENTS	0.00
COVERED CHARGES	100,034.20	CONTRACTUAL ALLOW	50,881.48
NON-COVERD CHARGES	936.00	TOTAL MEDICAID LIAB	49,152.72
		LESS: COB	49,152.72
		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	27		0	12,429.00		936.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	27		0	12,429.00		936.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	27		0	12,429.00		936.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,737.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,437.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,738.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	712.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	503.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,525.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,652.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,020.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,381.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,729.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,556.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,125.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,286.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	87,605.20	0.00
			TOTAL ACCOMODATIONS	12,429.00	936.00
			TOTAL CHARGES	100,034.20	936.00

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: 09/24/2013  
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DOCTORS HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,774,243.65	ADJUSTMENTS	72,305.71
COVERED CHARGES	5,150,182.34	CONTRACTUAL ALLOW	4,183,525.35
NON-COVERD CHARGES	624,061.31	TOTAL MEDICAID LIAB	966,656.99
		LESS: COB	7,933.52
		LESS: COPAYMENT	1,140.00
		REIMBURSEMENT	957,583.47
		ALL OTHER	837,765.38
		FEE SCHEDULE-LAB	97,207.80
		INJECTABLE DRUGS	22,610.29
		TOTAL NUMBER OF CLAIMS	1,769

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 18:54:10  
 Page: 6

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143,725.10	0.00	OTHER LAB	8,906.00	0.00
MED/SURG SUPPLY	281,337.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	241,741.00	675.00	OTHER THERAPEUTIC SVC	0.00	186.00
CT SCAN	556,514.00	31,481.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	672.00	FEE SCHEDULE LAB	1,202,880.24	150,231.64
EKG/ECG	50,216.95	0.00	MRI SERVICES	30,251.00	3,456.00
IV THERAPY	191,361.00	4,791.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	685,872.67	221,757.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,876.00	21,062.79	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,975.00	1,765.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	161,290.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,692.00	6,611.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	895,797.45	44,690.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	98,290.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	163,953.43	61,358.45
RADIOLOGY THERAPEUTIC	2,288.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	364.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,661.55	27,313.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,545.15	5,241.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	70,764.75	5,123.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,949.00	1,013.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,927.00	35,510.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,516.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	227,406.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,445.58	760.00			
			TOTAL ANCILLARY	5,150,182.34	624,061.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,150,182.34	624,061.31

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,395.59	ADJUSTMENTS	0.00
COVERED CHARGES	68,783.04	CONTRACTUAL ALLOW	39,173.77
NON-COVERD CHARGES	46,612.55	TOTAL MEDICAID LIAB	29,609.27
		LESS: COB	29,594.27
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 29

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,421.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,132.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,066.50	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	12,199.25	235.00
EKG/ECG	337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,552.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,250.30	41,861.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,626.87	3,292.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,267.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,340.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,617.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,884.13	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	245.42	227.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	311.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,872.01	686.25			
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	4,581.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	390.00	0.00			
			TOTAL ANCILLARY	68,783.04	46,612.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,783.04	46,612.55

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: 09/24/2013  
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DOCTORS HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	427,107.55	ADJUSTMENTS	485.46
COVERED CHARGES	406,842.55	CONTRACTUAL ALLOW	389,724.91
NON-COVERD CHARGES	20,265.00	TOTAL MEDICAID LIAB	17,117.64
		LESS: COB	0.00
		LESS: COPAYMENT	558.04
		REIMBURSEMENT	16,559.60
		TOTAL NUMBER OF CLAIMS	306

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,081.30	12.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,874.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,887.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,841.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	124,942.00	13,848.00
EKG/ECG	2,079.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,296.00	103.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,539.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,152.00	2,470.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,998.00	1,161.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,153.00	471.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,200.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	406,842.55	20,265.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	406,842.55	20,265.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,937.91	ADJUSTMENTS	0.00
COVERED CHARGES	12,623.91	CONTRACTUAL ALLOW	6,728.92
NON-COVERD CHARGES	314.00	TOTAL MEDICAID LIAB	5,894.99
		LESS: COB	5,888.99
		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

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	305.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	786.22	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	4,491.21	314.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	101.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,109.55	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	141.78	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	471.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,623.91	314.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,623.91	314.00

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	637,172.85	ADJUSTMENTS	9,992.74
COVERED CHARGES	612,304.65	CONTRACTUAL ALLOW	522,234.99
NON-COVERD CHARGES	24,868.20	TOTAL MEDICAID LIAB	90,069.66
		LESS: COB	0.00
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	89,901.66

TOTAL NUMBER OF CLAIMS 18

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,324.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	112,719.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,780.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,594.00	1,706.00
EKG/ECG	1,323.00	189.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,906.00	103.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	283,626.50	11,600.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	190.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,312.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	728.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,155.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,718.00	1,376.00
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	4,341.00	9,433.70
LITHOTRIPSY	56,030.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	471.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,888.00	460.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,198.00	0.00			
			TOTAL ANCILLARY	612,304.65	24,868.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	612,304.65	24,868.20

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:55:03  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER 000149487A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,660,822.97	ADJUSTMENTS	26,885.92
COVERED CHARGES	1,563,425.96	CONTRACTUAL ALLOW	832,604.95
NON-COVERD CHARGES	97,397.01	TOTAL MEDICAID LIAB	730,821.01
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	730,821.01

TOTAL NUMBER OF ADMISSIONS 154

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	882		0	441,000.00		85,135.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	882		0	441,000.00		85,135.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	882		0	441,000.00		85,135.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	409,222.40	0.00	OTHER LAB	4,844.97	0.00
MED/SURG SUPPLY	97,828.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	220,668.97	0.00	EDUCATION & TRAINING	260.00	0.00
RADIOLOGY-DIAGNOSTIC	20,618.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,871.26	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,691.73	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,958.67	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,332.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,850.00	6,760.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,030.87	172.14	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,662.64	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	108,422.82	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	24,209.04	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	2,783.58	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	58,852.48	4,911.69			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,149.22	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	1,166.96	418.18			
			TOTAL ANCILLARY	1,122,425.96	12,262.01
			TOTAL ACCOMODATIONS	441,000.00	85,135.00
			TOTAL CHARGES	1,563,425.96	97,397.01

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 18:55:08  
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BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,697,488.22	ADJUSTMENTS	0.00
COVERED CHARGES	1,590,341.81	CONTRACTUAL ALLOW	1,261,178.22
NON-COVERD CHARGES	107,146.41	TOTAL MEDICAID LIAB	329,163.59
		LESS: COB	118.44
		LESS: COPAYMENT	837.00
		REIMBURSEMENT	328,208.15
		ALL OTHER	283,975.38
		FEE SCHEDULE-LAB	43,205.83
		INJECTABLE DRUGS	1,026.94
		TOTAL NUMBER OF CLAIMS	1,606



BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,620.89	0.00	OTHER LAB	81,212.82	0.00
MED/SURG SUPPLY	35,262.21	766.81	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	375.43	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,686.15	896.67	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	103,862.35	5,415.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	674.70	0.00	FEE SCHEDULE LAB	314,164.26	89,197.09
EKG/ECG	29,890.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,439.29	1,428.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	256,956.04	874.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,195.34	258.14	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,787.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,960.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	475,112.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,602.53	2,238.71
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	79.11	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,539.47	0.00	IMPL DEV CHARGE PATIENTS	0.00	770.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	163.28
OTHER IMAGING SERVICE	9,422.86	650.39			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,584.08	3,508.35			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,284.04	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,084.36	524.52			
			TOTAL ANCILLARY	1,590,341.81	107,146.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,590,341.81	107,146.41

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: 09/24/2013  
Run Time: 18:55:08  
Page: 6

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212188008679	06/27/12 - 06/27/12	07/09/12	0.00	163.28	0.00	0.00	0.00
TOTAL				0.00	163.28	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 09/24/2013  
Run Time: 18:55:37  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,287.62	ADJUSTMENTS	0.00
COVERED CHARGES	6,000.14	CONTRACTUAL ALLOW	2,572.45
NON-COVERD CHARGES	287.48	TOTAL MEDICAID LIAB	3,427.69
		LESS: COB	3,427.69
		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

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	592.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,322.53	287.48
EKG/ECG	224.77	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	3,712.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,000.14	287.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,000.14	287.48

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:55:38  
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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	97,960.03	ADJUSTMENTS	0.00
COVERED CHARGES	96,466.65	CONTRACTUAL ALLOW	89,983.07
NON-COVERD CHARGES	1,493.38	TOTAL MEDICAID LIAB	6,483.58
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	6,258.58
		TOTAL NUMBER OF CLAIMS	116

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,919.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	55.42	341.56	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,056.64	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,337.34	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,377.55	1,040.73
EKG/ECG	674.31	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	390.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	423.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	73,873.83	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	92.63	111.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	265.37	0.00			
			TOTAL ANCILLARY	96,466.65	1,493.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,466.65	1,493.38

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: 09/24/2013  
Run Time: 18:55:40  
Page: 11

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,232.24	ADJUSTMENTS	0.00
COVERED CHARGES	40,232.24	CONTRACTUAL ALLOW	35,360.26
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,871.98
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,871.98
		TOTAL NUMBER OF CLAIMS	1



SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	829.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	489.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	37,440.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,356.16	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	117.47	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	40,232.24	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,232.24	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: 09/24/2013  
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Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:55:47  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER 000182388A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,124,803.24	ADJUSTMENTS	1,529,821.39
COVERED CHARGES	23,445,146.38	CONTRACTUAL ALLOW	16,595,702.74
NON-COVERD CHARGES	2,679,656.86	TOTAL MEDICAID LIAB	6,849,443.64
		LESS: COB	55,765.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,793,678.04

TOTAL NUMBER OF ADMISSIONS 760

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,893		31	1,702,226.14		145,366.55
ROUTINE NURSERY	255		0	94,920.21		725.74
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,148		31	1,797,146.35		146,092.29
SPECIAL CARE SERVICES						
CCU	698		5	1,318,868.81		111,952.92
ICU	2		0	4,490.20		0.00
NICU	406		0	464,445.14		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,106		5	1,787,804.15		111,952.92
TOTAL ACCOMODATIONS	4,254		36	3,584,950.50		258,045.21

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,592,721.93	369,442.25	OTHER LAB	113,285.43	8,864.94
MED/SURG SUPPLY	745,740.13	49,266.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,355,823.03	128,007.25	EDUCATION & TRAINING	9,865.47	334.62
RADIOLOGY-DIAGNOSTIC	587,649.85	21,266.91	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	766,929.30	63,285.99	SPECIAL CHARGES	1,295.14	0.00
PHYSICAL THERAPY	69,577.36	2,495.44	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	151,365.97	597.70	MRI SERVICES	223,383.39	0.00
IV THERAPY	1,021,441.26	985,555.37	PROFESSIONAL FEES	0.00	384.78
OPERATING ROOM	1,433,135.87	146,484.23	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	71,898.98	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	822,211.94	48,418.69	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	185,311.64	14,476.94	AMBULANCE	0.00	0.00
GI SERVICES	39,321.78	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	340,388.28	2,421.06	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,037.27	3,169.28	DRUG-SPECIFIC/HOME IV	0.00	48,228.62
LABORATORY PATHOLOGIC	142,006.18	0.00	INJECTABLE DRUGS	3,794,203.56	245,996.23
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,008.48	733.92	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	19,983.38	4,166.54	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	31,708.17	8,204.69	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	231.99	92,034.86	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	979,911.33	24,168.54
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	22,560.76
OTHER IMAGING SERVICE	199,164.68	1,607.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	232,063.17	46,230.41			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	176,556.98	53,156.07			
AUDIOLOGY	430.92	0.00			
CARDIOLOGY	492,094.38	5,061.34			
AMBULATORY SURGERY	1,595.52	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,309.32	1,071.81			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139,543.80	23,918.48			
			TOTAL ANCILLARY	19,860,195.88	2,421,611.65
			TOTAL ACCOMODATIONS	3,584,950.50	258,045.21
			TOTAL CHARGES	23,445,146.38	2,679,656.86

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 18:55:47  
 Page: 3

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2211208002271	07/14/11 - 07/19/11	08/01/11	0.00	2,698.50	0.00	0.00	0.00
615	2011234030719	08/14/11 - 08/16/11	08/29/11	0.00	2,293.73	0.00	0.00	0.00
615	2011242068732	08/07/11 - 08/23/11	09/05/11	0.00	2,293.73	0.00	0.00	0.00
615	2211349001824	12/05/11 - 12/08/11	12/19/11	0.00	2,293.73	0.00	0.00	0.00
615	2012033038283	01/13/12 - 01/15/12	02/06/12	0.00	2,293.73	0.00	0.00	0.00
615	2012110078319	04/09/12 - 04/13/12	04/23/12	0.00	2,293.73	0.00	0.00	0.00
615	2012179059060	10/23/11 - 10/25/11	07/02/12	0.00	2,293.73	0.00	0.00	0.00
618	2212237012721	03/26/12 - 04/02/12	08/27/12	0.00	756.21	0.00	0.00	0.00
618	5212291000145	02/07/12 - 02/17/12	10/22/12	0.00	756.21	0.00	0.00	0.00
615	5213004000087	03/04/12 - 03/31/12	01/14/13	0.00	2,293.73	0.00	0.00	0.00
615	2013071054683	06/02/12 - 06/06/12	03/18/13	0.00	2,293.73	0.00	0.00	0.00
TOTAL				0.00	22,560.76	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: 09/24/2013  
 Run Time: 18:56:05  
 Page: 4

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,628.57	ADJUSTMENTS	0.00
COVERED CHARGES	28,628.57	CONTRACTUAL ALLOW	24,498.81
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,129.76
		LESS: COB	4,129.76
		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	1,217.72		0.00
ROUTINE NURSERY	1		0	274.54		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	1,492.26		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	3		0	4,176.15		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	4,176.15		0.00
TOTAL ACCOMODATIONS	6		0	5,668.41		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,489.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,117.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,120.71	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	700.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	9,296.92	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,728.30	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	434.46	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	115.76	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,451.05	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	506.06	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,960.16	0.00
			TOTAL ACCOMODATIONS	5,668.41	0.00
			TOTAL CHARGES	28,628.57	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: 09/24/2013  
Run Time: 18:56:06  
Page: 6

HENRY GENERAL HOSPITAL  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,237,617.75	ADJUSTMENTS	721,942.38
COVERED CHARGES	12,916,656.90	CONTRACTUAL ALLOW	10,596,057.98
NON-COVERD CHARGES	1,320,960.85	TOTAL MEDICAID LIAB	2,320,598.92
		LESS: COB	4,577.20
		LESS: COPAYMENT	3,663.95
		REIMBURSEMENT	2,312,357.77
		ALL OTHER	2,096,343.65
		FEE SCHEDULE-LAB	186,424.68
		INJECTABLE DRUGS	29,589.44

TOTAL NUMBER OF CLAIMS 5,613



HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386,387.42	2,796.79	OTHER LAB	62,488.62	16,251.08
MED/SURG SUPPLY	174,706.48	1,056.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,399.51	EDUCATION & TRAINING	223.08	0.00
RADIOLOGY-DIAGNOSTIC	844,168.33	40,682.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,138,728.06	147,586.93	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,099.29	9,851.99	FEE SCHEDULE LAB	2,631,626.44	360,215.02
EKG/ECG	265,750.53	1,902.41	MRI SERVICES	210,252.31	9,484.74
IV THERAPY	513,683.15	18,806.17	PROFESSIONAL FEES	0.00	483.10
OPERATING ROOM	1,778,611.58	264,590.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	52,633.35	86.22	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	118,080.39	6,188.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	330,327.70	1,191.84	AMBULANCE	0.00	0.00
GI SERVICES	57,407.78	2,603.88	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,624,047.53	19,520.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	157,559.07	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	879,119.70	166,861.26
RADIOLOGY THERAPEUTIC	539.13	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	338.48	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	228.31	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,091.40	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	125,102.52	19,857.18	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	112,120.71	14,890.95
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,123.79
OTHER IMAGING SERVICE	526,622.81	54,402.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	21,306.57	10,512.18			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	340,601.23	96,026.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	300,909.34	43,930.28			
AMBULATORY SURGERY	1,196.59	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	130,759.03	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,598.16	0.00			
			TOTAL ANCILLARY	12,916,656.90	1,320,960.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,916,656.90	1,320,960.85

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 18:56:06  
 Page: 8

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2311258000065	07/28/11 - 07/28/11	09/19/11	0.00	174.12	0.00	0.00	0.00
615	5912004000700	11/16/11 - 11/16/11	01/09/12	0.00	2,293.73	0.00	0.00	0.00
616	2012089072537	03/12/12 - 03/12/12	04/02/12	0.00	803.00	0.00	0.00	0.00
616	2012089072537	03/12/12 - 03/12/12	04/02/12	0.00	803.00	0.00	0.00	0.00
618	2012089072537	03/12/12 - 03/12/12	04/02/12	0.00	756.21	0.00	0.00	0.00
615	2012242103479	06/27/12 - 06/27/12	09/03/12	0.00	2,293.73	0.00	0.00	0.00
TOTAL				0.00	7,123.79	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: 09/24/2013  
Run Time: 18:57:03  
Page: 9

SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRY GENERAL HOSPITAL  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,758.46	ADJUSTMENTS	0.00
COVERED CHARGES	12,109.69	CONTRACTUAL ALLOW	8,211.30
NON-COVERD CHARGES	648.77	TOTAL MEDICAID LIAB	3,898.39
		LESS: COB	3,892.57
		LESS: COPAYMENT	5.82
		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

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	154.50	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	715.18	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,431.05	394.82
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	408.62	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	524.79	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.12	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,418.76	253.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,251.36	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	270.51	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,814.99	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,071.81	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,109.69	648.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,109.69	648.77

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 18:57:04  
Page: 11

HENRY GENERAL HOSPITAL  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	720,953.47	ADJUSTMENTS	4,821.58
COVERED CHARGES	678,326.81	CONTRACTUAL ALLOW	640,626.23
NON-COVERD CHARGES	42,626.66	TOTAL MEDICAID LIAB	37,700.58
		LESS: COB	0.00
		LESS: COPAYMENT	1,245.10
		REIMBURSEMENT	36,455.48
		TOTAL NUMBER OF CLAIMS	674

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,593.34	884.86	OTHER LAB	7,698.18	0.00
MED/SURG SUPPLY	414.20	156.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	310.80	EDUCATION & TRAINING	111.54	0.00
RADIOLOGY-DIAGNOSTIC	31,632.41	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,783.18	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	197,454.59	10,627.61
EKG/ECG	14,453.50	0.00	MRI SERVICES	5,071.51	0.00
IV THERAPY	35,261.46	2,708.65	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	14,344.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	90.33	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,788.26	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,503.79	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	201,243.64	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	744.66	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75,224.26	4,721.86
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	455.60	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,331.41	6,623.78			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,719.40	0.00			
			TOTAL ANCILLARY	678,326.81	42,626.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	678,326.81	42,626.66

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 18:57:10  
Page: 13

HENRY GENERAL HOSPITAL  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
Run Time: 18:57:11  
Page: 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRY GENERAL HOSPITAL  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,988,374.72	ADJUSTMENTS	114,623.46
COVERED CHARGES	1,660,734.63	CONTRACTUAL ALLOW	1,491,404.57
NON-COVERD CHARGES	327,640.09	TOTAL MEDICAID LIAB	169,330.06
		LESS: COB	0.00
		LESS: COPAYMENT	118.90
		REIMBURSEMENT	169,211.16
		TOTAL NUMBER OF CLAIMS	31



SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRY GENERAL HOSPITAL  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,654.28	0.00	OTHER LAB	0.00	1,088.57
MED/SURG SUPPLY	108,954.90	67.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	111.54	0.00
RADIOLOGY-DIAGNOSTIC	61,001.67	30,242.52	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,901.20	3,615.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,318.01	14,511.09
EKG/ECG	6,944.15	502.93	MRI SERVICES	0.00	0.00
IV THERAPY	6,463.43	513.18	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	539,228.52	47,299.87	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	327.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	56,420.84	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,241.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,057.78	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	37,570.07	67,377.43
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	631.13	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	631.13	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	590,508.16	140,024.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,376.18	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,604.99	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,205.95	2,867.62			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	107,810.28	18,267.39			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,033.37	0.00			
			TOTAL ANCILLARY	1,660,734.63	327,640.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,660,734.63	327,640.09

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 18:57:13  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRY GENERAL HOSPITAL  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER 000190088A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,996,907.22	ADJUSTMENTS	966,048.27
COVERED CHARGES	29,896,102.97	CONTRACTUAL ALLOW	23,815,313.38
NON-COVERD CHARGES	3,100,804.25	TOTAL MEDICAID LIAB	6,080,789.59
		LESS: COB	91,384.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,989,404.97

TOTAL NUMBER OF ADMISSIONS 764

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,769		0	3,611,965.00		2,709,926.00
ROUTINE NURSERY	259		1	261,035.00		2,569.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,028		1	3,873,000.00		2,712,495.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	809		0	1,681,652.00		26,736.00
NICU	132		0	279,972.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	941		0	1,961,624.00		26,736.00
TOTAL ACCOMODATIONS	4,969		1	5,834,624.00		2,739,231.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,098,389.50	7,483.00	OTHER LAB	219,941.00	0.00
MED/SURG SUPPLY	2,289,631.25	34,954.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,094,470.91	46,412.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	669,915.00	4,291.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,436,746.00	21,504.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	164,726.00	7,605.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	257,181.00	0.00	MRI SERVICES	311,538.00	0.00
IV THERAPY	376.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	772,699.50	4,537.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	249,141.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,458,044.00	3,364.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	275,591.00	2,426.00	AMBULANCE	0.00	0.00
GI SERVICES	142,844.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	918,828.00	3,561.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	307,549.00	2,258.00	DRUG-SPECIFIC/HOME IV	0.00	854.00
LABORATORY PATHOLOGIC	132,987.61	0.00	INJECTABLE DRUGS	3,864,300.85	42,476.50
RADIOLOGY THERAPEUTIC	373.00	62,952.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	53,267.00	718.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	97,468.00	3,788.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	193,348.00	8,414.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,507.00	340.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	996,018.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	179,026.00	997.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	144,266.60	84,774.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	264,341.50	16,771.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	324,477.75	1,093.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	43,083.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	93,403.00	0.00			
			TOTAL ANCILLARY	24,061,478.97	361,573.25
			TOTAL ACCOMODATIONS	5,834,624.00	2,739,231.00
			TOTAL CHARGES	29,896,102.97	3,100,804.25

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER 000190088A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	354,230.25	ADJUSTMENTS	0.00
COVERED CHARGES	337,725.25	CONTRACTUAL ALLOW	199,691.61
NON-COVERD CHARGES	16,505.00	TOTAL MEDICAID LIAB	138,033.64
		LESS: COB	138,033.64
		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	35		0	33,508.00		15,753.00
ROUTINE NURSERY	24		0	32,072.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	59		0	65,580.00		15,753.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	5,013.00		0.00
NICU	9		0	19,089.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	12		0	24,102.00		0.00
TOTAL ACCOMODATIONS	71		0	89,682.00		15,753.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,316.00	0.00	OTHER LAB	2,290.00	0.00
MED/SURG SUPPLY	22,181.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,885.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,351.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,544.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	370.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	499.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,024.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,978.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,428.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,748.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,424.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,145.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,560.00	0.00	INJECTABLE DRUGS	25,490.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,250.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,470.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,577.00	752.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,112.00	0.00			
			TOTAL ANCILLARY	248,043.25	752.00
			TOTAL ACCOMODATIONS	89,682.00	15,753.00
			TOTAL CHARGES	337,725.25	16,505.00

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: 09/24/2013  
Run Time: 18:57:37  
Page: 5

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,761,141.56	ADJUSTMENTS	183,475.13
COVERED CHARGES	11,965,754.71	CONTRACTUAL ALLOW	9,765,785.37
NON-COVERD CHARGES	795,386.85	TOTAL MEDICAID LIAB	2,199,969.34
		LESS: COB	8,820.38
		LESS: COPAYMENT	3,041.42
		REIMBURSEMENT	2,188,107.54
		ALL OTHER	2,020,115.07
		FEE SCHEDULE-LAB	102,742.84
		INJECTABLE DRUGS	65,249.63
		TOTAL NUMBER OF CLAIMS	3,943

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	330,691.10	2,651.00	OTHER LAB	194,029.00	0.00
MED/SURG SUPPLY	338,203.75	261.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,027.00	235.00
RADIOLOGY-DIAGNOSTIC	678,512.00	9,463.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,433,803.50	82,890.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,590.00	15,682.00	FEE SCHEDULE LAB	2,239,801.45	139,822.30
EKG/ECG	213,829.00	1,996.00	MRI SERVICES	202,362.00	20,956.00
IV THERAPY	368,400.50	30,505.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	618,424.48	103,210.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,256.00	13,170.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,677.00	1,531.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	265,288.00	2,126.00	AMBULANCE	0.00	0.00
GI SERVICES	4,476.00	2,238.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,660,620.00	66,447.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	527,552.00	5,745.00	DRUG-SPECIFIC/HOME IV	3,250.38	4,154.92
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	597,600.25	111,972.87
RADIOLOGY THERAPEUTIC	198.00	1,655.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,338.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	6,132.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	126,934.00	12,503.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,575.00	34,310.75
LITHOTRIPSY	11,849.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	435,647.00	50,029.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,406.50	2,256.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	254,587.50	54,076.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	61,437.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,458.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	223,269.30	18,030.00			
			TOTAL ANCILLARY	11,965,754.71	795,386.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,965,754.71	795,386.85



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 18:58:22  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	237,567.00	ADJUSTMENTS	0.00
COVERED CHARGES	203,131.00	CONTRACTUAL ALLOW	170,941.03
NON-COVERD CHARGES	34,436.00	TOTAL MEDICAID LIAB	32,189.97
		LESS: COB	32,151.96
		LESS: COPAYMENT	38.01
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 63

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,573.00	0.00	OTHER LAB	3,188.00	0.00
MED/SURG SUPPLY	6,667.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,937.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,418.00	17,254.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54,541.00	6,674.00
EKG/ECG	4,491.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,306.00	297.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,979.00	2,927.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	474.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,252.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,176.00	887.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,855.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,266.00	1,657.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,474.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,935.00	4,339.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,609.00	401.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,990.00	0.00			
			TOTAL ANCILLARY	203,131.00	34,436.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	203,131.00	34,436.00

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: 09/24/2013  
Run Time: 18:58:24  
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EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	641,115.09	ADJUSTMENTS	691.22
COVERED CHARGES	620,033.09	CONTRACTUAL ALLOW	600,454.09
NON-COVERD CHARGES	21,082.00	TOTAL MEDICAID LIAB	19,579.00
		LESS: COB	0.00
		LESS: COPAYMENT	534.06
		REIMBURSEMENT	19,044.94
		TOTAL NUMBER OF CLAIMS	350

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,427.00	0.00	OTHER LAB	3,136.00	0.00
MED/SURG SUPPLY	4,708.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,690.00	417.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,006.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	177,597.00	6,004.00
EKG/ECG	7,445.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,322.00	2,135.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,093.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,466.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	310,384.00	103.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	4,333.84	3,976.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,871.50	4,128.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	156.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,759.00	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	5,638.00	3,606.00			
			TOTAL ANCILLARY	620,033.09	21,082.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	620,033.09	21,082.00



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	165.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,821.00	34.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,084.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,788.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	149.00	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	2,982.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	2,404.00			
			TOTAL ANCILLARY	28,311.00	2,591.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,311.00	2,591.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII

Run Date: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,295,835.75	ADJUSTMENTS	34,745.82
COVERED CHARGES	1,194,074.06	CONTRACTUAL ALLOW	1,014,663.44
NON-COVERD CHARGES	101,761.69	TOTAL MEDICAID LIAB	179,410.62
		LESS: COB	0.00
		LESS: COPAYMENT	205.98
		REIMBURSEMENT	179,204.64

TOTAL NUMBER OF CLAIMS 35

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,329.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	139,140.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,185.00	217.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,722.00	11,340.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,110.00	FEE SCHEDULE LAB	55,201.40	8,603.60
EKG/ECG	6,487.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,512.00	852.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	134,168.41	27,443.09	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,672.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	56,501.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,718.00	4,501.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,049.00	103.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	73,004.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	316,813.00	7,588.00
RADIOLOGY THERAPEUTIC	0.00	1,520.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	876.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	60.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	179,212.50	30,739.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,988.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,072.25	4,405.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,084.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,215.00	2,404.00			
			TOTAL ANCILLARY	1,194,074.06	101,761.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,194,074.06	101,761.69



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VIII

Run Date: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER 000206181A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,071,966.50	ADJUSTMENTS	19,494.35
COVERED CHARGES	2,038,319.50	CONTRACTUAL ALLOW	860,098.93
NON-COVERD CHARGES	33,647.00	TOTAL MEDICAID LIAB	1,178,220.57
		LESS: COB	3,071.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,175,149.09

TOTAL NUMBER OF ADMISSIONS 253

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	653		0	401,595.00		32,990.00
ROUTINE NURSERY	63		0	35,280.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	716		0	436,875.00		32,990.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	716		0	436,875.00		32,990.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	710,132.50	0.00	OTHER LAB	4,027.00	0.00
MED/SURG SUPPLY	254,315.00	187.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	205,528.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,839.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,922.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,672.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,350.00	0.00	MRI SERVICES	9,525.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	149,400.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,126.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,472.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,946.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	356.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,617.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,675.00	470.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,844.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,782.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,986.00	0.00			
			TOTAL ANCILLARY	1,601,444.50	657.00
			TOTAL ACCOMODATIONS	436,875.00	32,990.00
			TOTAL CHARGES	2,038,319.50	33,647.00

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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,744,071.00	ADJUSTMENTS	6,922.96
COVERED CHARGES	1,613,803.00	CONTRACTUAL ALLOW	1,262,065.06
NON-COVERD CHARGES	130,268.00	TOTAL MEDICAID LIAB	351,737.94
		LESS: COB	0.00
		LESS: COPAYMENT	1,077.00
		REIMBURSEMENT	350,660.94
		ALL OTHER	303,430.64
		FEE SCHEDULE-LAB	47,210.33
		INJECTABLE DRUGS	19.97
		TOTAL NUMBER OF CLAIMS	1,422

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213,158.00	3,830.00	OTHER LAB	5,618.00	602.00
MED/SURG SUPPLY	203,504.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,819.00	936.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,198.00	3,068.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,471.00	3,573.00	FEE SCHEDULE LAB	483,324.00	80,347.00
EKG/ECG	10,360.00	70.00	MRI SERVICES	5,348.00	0.00
IV THERAPY	40,539.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	170,108.00	34,371.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,404.00	37.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,417.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	138,112.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	80,340.00	1,030.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	95.00	156.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,590.00	616.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,480.00	235.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,533.00	922.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,304.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,081.00	475.00			
			TOTAL ANCILLARY	1,613,803.00	130,268.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,613,803.00	130,268.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC  
102 HOSPITAL CIR  
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,841.00	ADJUSTMENTS	0.00
COVERED CHARGES	16,400.00	CONTRACTUAL ALLOW	6,824.06
NON-COVERD CHARGES	2,441.00	TOTAL MEDICAID LIAB	9,575.94
		LESS: COB	9,575.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	149.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	142.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	587.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,734.00	2,441.00
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	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	537.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,411.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,935.00	0.00			
			TOTAL ANCILLARY	16,400.00	2,441.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,400.00	2,441.00



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: 09/24/2013  
Run Time: 18:59:04  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,495.00	ADJUSTMENTS	0.00
COVERED CHARGES	80,964.00	CONTRACTUAL ALLOW	74,530.90
NON-COVERD CHARGES	2,531.00	TOTAL MEDICAID LIAB	6,433.10
		LESS: COB	0.00
		LESS: COPAYMENT	207.00
		REIMBURSEMENT	6,226.10
		TOTAL NUMBER OF CLAIMS	115

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,162.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,235.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,491.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,265.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,388.00	2,531.00
EKG/ECG	560.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	102.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,263.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	856.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	642.00	0.00			
			TOTAL ANCILLARY	80,964.00	2,531.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,964.00	2,531.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSPITAL INC  
102 HOSPITAL CIR  
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
000206181A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC  
102 HOSPITAL CIR  
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	128,861.00	ADJUSTMENTS	4,964.55
COVERED CHARGES	127,976.00	CONTRACTUAL ALLOW	98,170.70
NON-COVERD CHARGES	885.00	TOTAL MEDICAID LIAB	29,805.30
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	29,781.30
		TOTAL NUMBER OF CLAIMS	6

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,815.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	76,236.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	177.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,000.00	57.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,183.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	385.00	828.00	FREE STANDING CLINIC	0.00	0.00
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	6,180.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	127,976.00	885.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	127,976.00	885.00

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: 09/24/2013  
Run Time: 18:59:05  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 18:59:12  
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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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,614,287.23	ADJUSTMENTS	3,850,434.79
COVERED CHARGES	15,027,050.73	CONTRACTUAL ALLOW	8,610,998.96
NON-COVERD CHARGES	587,236.50	TOTAL MEDICAID LIAB	6,416,051.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,416,051.77

TOTAL NUMBER OF ADMISSIONS 94

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,604		0	4,192,058.00		133,506.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		9,568.00
TOTAL ROUTINE	3,604		0	4,192,058.00		143,074.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	115		0	275,200.00		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	115		0	275,200.00		0.00
TOTAL ACCOMODATIONS	3,719		0	4,467,258.00		143,074.00

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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,130,415.05	2,075.50	OTHER LAB	127,243.00	0.00
MED/SURG SUPPLY	2,176,375.73	5,510.00	RECREATIONAL THERAPY	143,922.00	93,282.00
LABORATORY-GENERAL	364,380.00	19,756.00	EDUCATION & TRAINING	151,010.00	39,373.00
RADIOLOGY-DIAGNOSTIC	205,951.00	0.00	OTHER THERAPEUTIC SVC	0.00	9,876.00
CT SCAN	120,424.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	989,294.00	50,245.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,680.00	0.00	MRI SERVICES	35,006.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	621,727.65	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,048,820.00	120,142.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	101.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,272.00	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	65,601.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	950,810.00	34,672.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	357,475.00	18,291.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	3,045.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,397.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	32,581.00
OTHER IMAGING SERVICE	6,796.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,397.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,695.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,084.00	0.00			
AMBULATORY SURGERY	23,267.00	10,917.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,310.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,736.00	0.00			
			TOTAL ANCILLARY	10,559,792.73	444,162.50
			TOTAL ACCOMODATIONS	4,467,258.00	143,074.00
			TOTAL CHARGES	15,027,050.73	587,236.50



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 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2011168047255	05/11/11 - 05/28/11	06/20/11	0.00	424.00	0.00	0.00	0.00
952	2011182069495	05/19/11 - 06/21/11	07/04/11	0.00	2,042.00	0.00	0.00	0.00
952	2211207014385	06/01/11 - 06/21/11	08/01/11	0.00	374.00	0.00	0.00	0.00
952	2211214006764	06/27/11 - 07/17/11	08/08/11	0.00	742.00	0.00	0.00	0.00
952	2211224019230	04/25/11 - 06/24/11	08/15/11	0.00	154.00	0.00	0.00	0.00
952	5211257000944	06/06/11 - 07/21/11	09/19/11	0.00	472.00	0.00	0.00	0.00
952	2011263026060	06/23/11 - 09/06/11	09/26/11	0.00	1,783.00	0.00	0.00	0.00
952	2211273011255	08/18/11 - 09/21/11	10/03/11	0.00	268.00	0.00	0.00	0.00
952	2211283005597	04/27/11 - 06/16/11	10/17/11	0.00	2,076.00	0.00	0.00	0.00
952	2211326000119	09/13/11 - 11/04/11	11/28/11	0.00	1,348.00	0.00	0.00	0.00
952	5211343001274	06/14/11 - 07/27/11	12/19/11	0.00	1,272.00	0.00	0.00	0.00
952	5211347001271	08/01/11 - 10/05/11	12/19/11	0.00	2,196.00	0.00	0.00	0.00
952	2211348002015	06/20/11 - 08/09/11	12/19/11	0.00	770.00	0.00	0.00	0.00
952	5211349001275	08/01/11 - 09/07/11	12/19/11	0.00	1,141.00	0.00	0.00	0.00
952	5211356001385	05/06/11 - 06/04/11	12/26/11	0.00	636.00	0.00	0.00	0.00
952	2211363000223	11/03/11 - 12/08/11	01/02/12	0.00	226.00	0.00	0.00	0.00
952	2012025083920	09/27/11 - 11/10/11	01/30/12	0.00	1,724.00	0.00	0.00	0.00
952	2212047009572	10/27/11 - 11/30/11	02/20/12	0.00	346.00	0.00	0.00	0.00
952	5212062001078	09/01/11 - 10/14/11	03/12/12	0.00	583.00	0.00	0.00	0.00
952	5012086981001	04/07/11 - 06/30/11	04/02/12	0.00	717.00	0.00	0.00	0.00
952	5012086981002	04/01/11 - 05/11/11	04/02/12	0.00	756.00	0.00	0.00	0.00
952	2012093026658	01/02/12 - 02/16/12	04/09/12	0.00	901.00	0.00	0.00	0.00
952	2012101047073	01/05/12 - 02/09/12	04/16/12	0.00	1,325.00	0.00	0.00	0.00
952	2012107017909	01/13/12 - 03/28/12	04/23/12	0.00	2,784.00	0.00	0.00	0.00
952	2012138048352	03/28/12 - 05/02/12	05/21/12	0.00	798.00	0.00	0.00	0.00
952	5212153000079	10/18/11 - 01/17/12	06/11/12	0.00	106.00	0.00	0.00	0.00
952	5212158000001	11/03/11 - 01/03/12	06/11/12	0.00	212.00	0.00	0.00	0.00
952	5212172000071	08/03/11 - 09/13/11	06/25/12	0.00	1,309.00	0.00	0.00	0.00
952	9112185000001	04/22/11 - 07/15/11	07/09/12	0.00	636.00	0.00	0.00	0.00
952	5212191000067	02/29/12 - 03/30/12	07/16/12	0.00	742.00	0.00	0.00	0.00
952	5212192000074	02/24/12 - 04/03/12	07/16/12	0.00	631.00	0.00	0.00	0.00
952	2012222002183	02/17/12 - 04/13/12	08/13/12	0.00	1,050.00	0.00	0.00	0.00
952	5212221000022	02/01/12 - 03/07/12	08/13/12	0.00	371.00	0.00	0.00	0.00
952	5212227000083	03/29/12 - 05/10/12	08/20/12	0.00	504.00	0.00	0.00	0.00
952	5212236000090	03/21/12 - 05/31/12	08/27/12	0.00	392.00	0.00	0.00	0.00
952	5212354000131	12/22/11 - 02/09/12	12/24/12	0.00	770.00	0.00	0.00	0.00
TOTAL				0.00	32,581.00	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: 09/24/2013  
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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 04/01/11 THROUGH 03/31/12  
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: 09/24/2013  
Run Time: 18:59:16  
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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 04/01/11 THROUGH 03/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,414,297.55	ADJUSTMENTS	102,412.67
COVERED CHARGES	1,792,192.85	CONTRACTUAL ALLOW	1,063,524.40
NON-COVERD CHARGES	622,104.70	TOTAL MEDICAID LIAB	728,668.45
		LESS: COB	0.00
		LESS: COPAYMENT	4,962.00
		REIMBURSEMENT	723,706.45
		ALL OTHER	452,712.23
		FEE SCHEDULE-LAB	15,881.28
		INJECTABLE DRUGS	255,112.94

TOTAL NUMBER OF CLAIMS 1,754

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
 ATLANTA, GA 30309-1426

PROVIDER NUMBER  
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/11 THROUGH 03/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,053.60	307.00	OTHER LAB	13,870.00	1,580.00
MED/SURG SUPPLY	39,764.00	0.00	RECREATIONAL THERAPY	910.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	144.00	0.00
RADIOLOGY-DIAGNOSTIC	38,808.00	2,320.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	85,890.00	42,752.00	FEE SCHEDULE LAB	145,520.00	3,912.80
EKG/ECG	2,560.00	0.00	MRI SERVICES	263,368.00	30,627.00
IV THERAPY	20,462.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	568.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	270.00	AMBULANCE	0.00	0.00
GI SERVICES	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	687,220.25	404,051.90
RADIOLOGY THERAPEUTIC	42,330.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,170.00	52,242.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	34,406.00	17,262.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	242,811.00	21,565.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	15,952.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,158.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	21,244.00	13,621.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	63,936.00	15,642.00			
			TOTAL ANCILLARY	1,792,192.85	622,104.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,792,192.85	622,104.70

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

SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/11	THROUGH	03/31/12
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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SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/11	THROUGH	03/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/11	THROUGH	03/31/12
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	04/01/11	THROUGH	03/31/12
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

SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/11	THROUGH	03/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,008,769.31	ADJUSTMENTS	2,082,920.33
COVERED CHARGES	40,386,692.47	CONTRACTUAL ALLOW	33,293,893.34
NON-COVERD CHARGES	622,076.84	TOTAL MEDICAID LIAB	7,092,799.13
		LESS: COB	55,387.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,037,411.91

TOTAL NUMBER OF ADMISSIONS 1,664

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,471		2	2,775,608.50		169,658.00
ROUTINE NURSERY	1,994		0	1,905,260.20		21,548.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,465		2	4,680,868.70		191,206.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	803		0	2,646,198.00		22,640.00
NICU	21		0	90,908.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	824		0	2,737,106.00		22,640.00
TOTAL ACCOMODATIONS	5,289		2	7,417,974.70		213,846.50

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,171,417.60	59,007.00	OTHER LAB	246,925.70	1,794.90
MED/SURG SUPPLY	5,111,500.33	119,444.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,701,958.30	17,373.00	EDUCATION & TRAINING	213.60	0.00
RADIOLOGY-DIAGNOSTIC	268,781.70	1,205.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	833,134.10	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	131,330.50	28,642.10	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	101,255.90	0.00	MRI SERVICES	110,253.50	0.00
IV THERAPY	46,520.60	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,939,191.84	20,869.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,089,407.00	14,538.20	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,732,043.40	5,600.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	752,087.00	2,822.80	AMBULANCE	0.00	0.00
GI SERVICES	99,528.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	661,189.10	15,038.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	934,443.30	1,718.10	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	149,655.90	0.00	INJECTABLE DRUGS	6,306.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	46,167.10	27,224.20	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	82,705.20	15,439.40	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	34,028.70	4,685.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60,214.70	683.80	TRAUMA RESPONSE	0.00	12,302.10
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	527,962.30	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	242,292.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	191,360.60	59,652.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	89,638.50	0.00			
AUDIOLOGY	245,621.60	0.00			
CARDIOLOGY	267,645.40	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,429.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,507.20	188.00			
			TOTAL ANCILLARY	32,968,717.77	408,230.34
			TOTAL ACCOMODATIONS	7,417,974.70	213,846.50
			TOTAL CHARGES	40,386,692.47	622,076.84

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: 09/24/2013  
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NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2312096000012	02/06/12 - 02/08/12	07/02/12	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

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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	130,987.90	ADJUSTMENTS	0.00
COVERED CHARGES	130,407.90	CONTRACTUAL ALLOW	115,587.91
NON-COVERD CHARGES	580.00	TOTAL MEDICAID LIAB	14,819.99
		LESS: COB	14,819.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11		0	12,498.50		524.50
ROUTINE NURSERY	10		0	21,079.00		55.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	21		0	33,577.50		580.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	21		0	33,577.50		580.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,520.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,959.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,508.50	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	31,054.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,160.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,580.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,420.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	641.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	984.60	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	96,830.40	0.00
			TOTAL ACCOMODATIONS	33,577.50	580.00
			TOTAL CHARGES	130,407.90	580.00

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: 09/24/2013  
Run Time: 19:00:47  
Page: 6

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,567,560.45	ADJUSTMENTS	454,776.63
COVERED CHARGES	7,606,719.70	CONTRACTUAL ALLOW	6,298,835.16
NON-COVERD CHARGES	960,840.75	TOTAL MEDICAID LIAB	1,307,884.54
		LESS: COB	14,931.93
		LESS: COPAYMENT	1,389.00
		REIMBURSEMENT	1,291,563.61
		ALL OTHER	1,233,926.75
		FEE SCHEDULE-LAB	52,354.78
		INJECTABLE DRUGS	5,282.08

TOTAL NUMBER OF CLAIMS 2,144

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	340,953.30	18,388.50	OTHER LAB	44,454.00	794.50
MED/SURG SUPPLY	537,514.30	2,644.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	46.40	EDUCATION & TRAINING	0.00	142.40
RADIOLOGY-DIAGNOSTIC	358,454.40	4,313.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	973,016.80	52,088.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,922.20	FEE SCHEDULE LAB	1,468,136.10	411,988.40
EKG/ECG	107,604.40	3,616.70	MRI SERVICES	126,968.70	12,369.90
IV THERAPY	479,942.30	121,105.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	375,051.20	34,218.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,488.40	9,829.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,954.00	0.00	AMBULANCE	0.00	2,681.00
GI SERVICES	27,252.30	3,617.40	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,365,526.10	24,229.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,893.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	510,428.20	130,701.50
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	18,412.10	1,094.80	TRAUMA RESPONSE	0.00	1,811.20
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,144.30	21,469.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	273,765.60	29,861.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,334.60	2,153.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	63,497.20	3,146.30			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,565.80	0.00			
AMBULATORY SURGERY	115,628.00	35,752.85			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	47,367.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,366.90	29,853.70			
			TOTAL ANCILLARY	7,606,719.70	960,840.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,606,719.70	960,840.75



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: 09/24/2013  
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Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	318,413.50	ADJUSTMENTS	0.00
COVERED CHARGES	230,933.50	CONTRACTUAL ALLOW	121,324.33
NON-COVERD CHARGES	87,480.00	TOTAL MEDICAID LIAB	109,609.17
		LESS: COB	109,576.17
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 58

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,830.40	305.00	OTHER LAB	4,518.60	0.00
MED/SURG SUPPLY	12,669.70	467.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,651.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,080.70	16,438.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	59,501.20	12,164.30
EKG/ECG	3,646.60	597.80	MRI SERVICES	0.00	0.00
IV THERAPY	25,575.50	2,172.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,604.70	2,604.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	653.80	237.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,099.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,840.10	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	19,126.80	10,659.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	621.70	356.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	15,481.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,912.80	2,096.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,792.00	2,760.80			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,943.30	15,975.20			
AMBULATORY SURGERY	0.00	4,223.40			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,864.10	939.40			
			TOTAL ANCILLARY	230,933.50	87,480.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	230,933.50	87,480.00

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: 09/24/2013  
Run Time: 19:01:42  
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NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	608,560.10	ADJUSTMENTS	1,491.32
COVERED CHARGES	549,709.90	CONTRACTUAL ALLOW	535,445.21
NON-COVERD CHARGES	58,850.20	TOTAL MEDICAID LIAB	14,264.69
		LESS: COB	0.00
		LESS: COPAYMENT	492.01
		REIMBURSEMENT	13,772.68
		TOTAL NUMBER OF CLAIMS	255

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,870.10	0.00	OTHER LAB	5,091.00	0.00
MED/SURG SUPPLY	12,048.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,210.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,717.20	15,900.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	101,244.50	13,996.60
EKG/ECG	10,282.20	0.00	MRI SERVICES	9,797.80	6,215.20
IV THERAPY	40,458.20	4,681.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,118.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	2,246.90
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	236,900.70	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	43,776.60	7,259.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,194.70	3,446.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	5,103.10			
			TOTAL ANCILLARY	549,709.90	58,850.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	549,709.90	58,850.20

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,530.00	ADJUSTMENTS	0.00
COVERED CHARGES	39,604.70	CONTRACTUAL ALLOW	29,085.36
NON-COVERD CHARGES	2,925.30	TOTAL MEDICAID LIAB	10,519.34
		LESS: COB	10,507.34
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 19:01:48  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	513.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,250.80	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	15,306.10	1,672.80
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,771.90	394.30	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,207.70	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	2,412.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,142.20	858.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	39,604.70	2,925.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,604.70	2,925.30

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,247,464.27	ADJUSTMENTS	41,067.40
COVERED CHARGES	1,080,158.28	CONTRACTUAL ALLOW	925,351.37
NON-COVERD CHARGES	167,305.99	TOTAL MEDICAID LIAB	154,806.91
		LESS: COB	4,813.60
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	149,960.31
		TOTAL NUMBER OF CLAIMS	30

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,317.50	2,975.30	OTHER LAB	1,501.20	0.00
MED/SURG SUPPLY	241,036.87	948.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	71.20
RADIOLOGY-DIAGNOSTIC	14,073.50	2,151.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,340.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	86,399.60	12,077.80
EKG/ECG	4,782.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,145.80	21,398.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	222,514.01	46,051.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	49,678.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,808.70	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,592.50	6,285.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,042.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	68,741.00	29,146.10
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	1,708.60	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	510.30	TRAUMA RESPONSE	0.00	2,354.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	678.80	28,739.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,280.40	3,475.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,034.80	861.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,687.80	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,190.60	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	20,938.10	6,742.00			
			TOTAL ANCILLARY	1,080,158.28	167,305.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,080,158.28	167,305.99



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: 09/24/2013  
Run Time: 19:01:51  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 19:02:02  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,266,479.50	ADJUSTMENTS	143,620.78
COVERED CHARGES	4,052,824.25	CONTRACTUAL ALLOW	2,818,772.91
NON-COVERD CHARGES	213,655.25	TOTAL MEDICAID LIAB	1,234,051.34
		LESS: COB	7,585.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,226,465.37

TOTAL NUMBER OF ADMISSIONS 142

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	575		0	466,325.00		122,130.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	575		0	466,325.00		122,130.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	100		0	244,912.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	100		0	244,912.00		0.00
TOTAL ACCOMODATIONS	675		0	711,237.00		122,130.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313,585.25	0.50	OTHER LAB	27,357.50	0.00
MED/SURG SUPPLY	163,664.00	499.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	755,942.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	115,894.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	113,322.25	55,687.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,484.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	32,419.25	0.00	MRI SERVICES	32,505.50	0.00
IV THERAPY	37,166.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	241,160.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	212,936.25	866.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,757.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,104.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,666.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,907.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	23,676.00
LABORATORY PATHOLOGIC	2,479.75	0.00	INJECTABLE DRUGS	645,786.25	1,212.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,441.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,399.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	17,760.00	6,830.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	122,507.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,887.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,688.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,899.00	2,752.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	82,114.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,666.00	0.00			
			TOTAL ANCILLARY	3,341,587.25	91,525.25
			TOTAL ACCOMODATIONS	711,237.00	122,130.00
			TOTAL CHARGES	4,052,824.25	213,655.25

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,131.26	ADJUSTMENTS	0.00
COVERED CHARGES	4,131.26	CONTRACTUAL ALLOW	3,456.68
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	674.58
		LESS: COB	674.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	2,433.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	2,433.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	2,433.00		0.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	133.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	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	443.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,122.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,698.26	0.00
			TOTAL ACCOMODATIONS	2,433.00	0.00
			TOTAL CHARGES	4,131.26	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 19:02:07  
Page: 5

COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,488,568.80	ADJUSTMENTS	37,333.49
COVERED CHARGES	3,169,575.90	CONTRACTUAL ALLOW	2,550,022.22
NON-COVERD CHARGES	318,992.90	TOTAL MEDICAID LIAB	619,553.68
		LESS: COB	1,596.63
		LESS: COPAYMENT	933.00
		REIMBURSEMENT	617,024.05
		ALL OTHER	575,383.31
		FEE SCHEDULE-LAB	38,035.55
		INJECTABLE DRUGS	3,605.19
		TOTAL NUMBER OF CLAIMS	1,471

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 19:02:07  
 Page: 6

COLISEUM NORTHSIDE HOSPITAL  
 400 CHARTER BLVD  
 MACON,GA 31210-4831

PROVIDER NUMBER  
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,886.25	0.00	OTHER LAB	95,187.25	0.00
MED/SURG SUPPLY	58,476.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	323,638.75	2,815.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	481,026.75	85,806.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,332.75	11,682.00	FEE SCHEDULE LAB	545,548.50	53,935.25
EKG/ECG	37,140.50	314.75	MRI SERVICES	60,153.50	3,795.50
IV THERAPY	85,651.25	2,327.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	254,339.85	87,687.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,360.25	2,476.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,542.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,104.25	6,471.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	849,785.50	1,550.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,673.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,587.05	47,382.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,305.75	171.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,411.00	410.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,480.25	681.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,528.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54,268.50	2,951.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,327.75	8,535.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,408.00	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	12,412.75	0.00			
			TOTAL ANCILLARY	3,169,575.90	318,992.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,169,575.90	318,992.90

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 19:02:37  
Page: 7

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,138.75	ADJUSTMENTS	0.00
COVERED CHARGES	36,382.00	CONTRACTUAL ALLOW	21,662.39
NON-COVERD CHARGES	12,756.75	TOTAL MEDICAID LIAB	14,719.61
		LESS: COB	14,717.82
		LESS: COPAYMENT	1.79
		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

COLISEUM NORTHSIDE HOSPITAL  
 400 CHARTER BLVD  
 MACON,GA 31210-4831

PROVIDER NUMBER  
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	784.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	159.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,901.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,820.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,844.00	1,393.00
EKG/ECG	1,259.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	359.25	59.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,008.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,525.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,355.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	198.25	443.75
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	40.50	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	1,989.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	36,382.00	12,756.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,382.00	12,756.75

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	354,371.75	ADJUSTMENTS	376.58
COVERED CHARGES	343,316.50	CONTRACTUAL ALLOW	324,464.72
NON-COVERD CHARGES	11,055.25	TOTAL MEDICAID LIAB	18,851.78
		LESS: COB	0.00
		LESS: COPAYMENT	651.01
		REIMBURSEMENT	18,200.77
		TOTAL NUMBER OF CLAIMS	337

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,922.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	605.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,075.25	376.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,604.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	57,216.75	2,659.50
EKG/ECG	2,832.75	0.00	MRI SERVICES	3,795.50	0.00
IV THERAPY	7,187.75	403.50	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	269.50	404.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	209,565.00	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	6,055.25	6,283.25
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	174.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,187.25	755.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	343,316.50	11,055.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	343,316.50	11,055.25

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,474.50	ADJUSTMENTS	0.00
COVERED CHARGES	3,452.25	CONTRACTUAL ALLOW	2,026.59
NON-COVERD CHARGES	22.25	TOTAL MEDICAID LIAB	1,425.66
		LESS: COB	1,419.66
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 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	1,532.75	22.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,919.50	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	3,452.25	22.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,452.25	22.25

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	276,016.75	ADJUSTMENTS	5,473.81
COVERED CHARGES	254,389.75	CONTRACTUAL ALLOW	216,025.83
NON-COVERD CHARGES	21,627.00	TOTAL MEDICAID LIAB	38,363.92
		LESS: COB	0.00
		LESS: COPAYMENT	39.75
		REIMBURSEMENT	38,324.17

TOTAL NUMBER OF CLAIMS 7

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM NORTHSIDE HOSPITAL  
 400 CHARTER BLVD  
 MACON,GA 31210-4831

PROVIDER NUMBER  
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,346.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,326.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,690.25	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	1,032.00	FEE SCHEDULE LAB	3,031.75	589.50
EKG/ECG	314.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	98,835.25	17,977.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,461.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,502.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,022.50	1,408.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	619.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	96.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	106,763.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	254,389.75	21,627.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	254,389.75	21,627.00

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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 19:03:56  
 Page: 1

HUGHSTON HOSPITAL  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER 000315642A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,887,510.11	ADJUSTMENTS	73,735.89
COVERED CHARGES	1,873,142.11	CONTRACTUAL ALLOW	1,371,638.51
NON-COVERD CHARGES	14,368.00	TOTAL MEDICAID LIAB	501,503.60
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	501,503.60

TOTAL NUMBER OF ADMISSIONS 32

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	89		0	72,090.00		10,800.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	89		0	72,090.00		10,800.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	8,405.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	8,405.00		0.00
TOTAL ACCOMODATIONS	94		0	80,495.00		10,800.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,022.50	0.00	OTHER LAB	1,336.25	0.00
MED/SURG SUPPLY	169,084.25	48.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	37,305.75	80.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,314.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,980.09	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,098.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	419,043.95	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,124.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	79,091.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	52,750.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,787.50	3,439.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,921.44	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	69.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	834,938.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,805.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	972.32	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,792,647.11	3,568.00
			TOTAL ACCOMODATIONS	80,495.00	10,800.00
			TOTAL CHARGES	1,873,142.11	14,368.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER 000315642A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,922.96	ADJUSTMENTS	0.00
COVERED CHARGES	49,562.96	CONTRACTUAL ALLOW	29,999.41
NON-COVERD CHARGES	360.00	TOTAL MEDICAID LIAB	19,563.55
		LESS: COB	19,563.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	3,240.00		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	4		0	3,240.00		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	4		0	3,240.00		360.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HUGHSTON HOSPITAL  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,575.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,929.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,786.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	254.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	855.48	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	182.28	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,198.01	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,301.06	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,565.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,346.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	309.36	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,047.50	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.	972.32	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	46,322.96	0.00
			TOTAL ACCOMODATIONS	3,240.00	360.00
			TOTAL CHARGES	49,562.96	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: 09/24/2013  
Run Time: 19:03:56  
Page: 5

HUGHSTON HOSPITAL  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	273,815.17	ADJUSTMENTS	6,523.87
COVERED CHARGES	217,883.25	CONTRACTUAL ALLOW	171,135.46
NON-COVERD CHARGES	55,931.92	TOTAL MEDICAID LIAB	46,747.79
		LESS: COB	0.00
		LESS: COPAYMENT	147.00
		REIMBURSEMENT	46,600.79
		ALL OTHER	45,875.78
		FEE SCHEDULE-LAB	656.15
		INJECTABLE DRUGS	68.86

TOTAL NUMBER OF CLAIMS 56

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 19:03:56  
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HUGHSTON HOSPITAL  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,343.50	0.00	OTHER LAB	2,672.50	0.00
MED/SURG SUPPLY	18,128.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,332.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,023.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,373.57	FEE SCHEDULE LAB	9,298.96	797.00
EKG/ECG	1,640.52	182.28	MRI SERVICES	37,238.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,803.32	23,981.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	478.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,635.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,706.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,093.00	1,313.75
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	14,454.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,577.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,912.44	12,829.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	217,883.25	55,931.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	217,883.25	55,931.92

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

HUGHSTON HOSPITAL  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,431.03	ADJUSTMENTS	0.00
COVERED CHARGES	6,386.24	CONTRACTUAL ALLOW	4,976.04
NON-COVERD CHARGES	6,044.79	TOTAL MEDICAID LIAB	1,410.20
		LESS: COB	1,404.20
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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: 09/24/2013  
 Run Time: 19:03:57  
 Page: 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHSTON HOSPITAL  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	811.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,701.75	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	147.23	FEE SCHEDULE LAB	408.75	20.00
EKG/ECG	182.28	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	5,877.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,716.51	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,565.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,386.24	6,044.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,386.24	6,044.79



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 09/24/2013  
Run Time: 19:03:57  
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HUGHSTON HOSPITAL  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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HUGHSTON HOSPITAL  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	80,910.82	ADJUSTMENTS	0.00
COVERED CHARGES	75,460.63	CONTRACTUAL ALLOW	59,496.52
NON-COVERD CHARGES	5,450.19	TOTAL MEDICAID LIAB	15,964.11
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	15,952.11

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 19:03:57  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,866.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,976.50	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	614.94	FEE SCHEDULE LAB	121.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,886.36	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,955.37	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,538.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85.75	815.25
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	16,556.00	4,020.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	75,460.63	5,450.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	75,460.63	5,450.19

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 09/24/2013  
Run Time: 19:03:58  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHSTON HOSPITAL  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 19:04:05  
 Page: 1

WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER 000339831A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,769,585.53	ADJUSTMENTS	887,120.69
COVERED CHARGES	5,264,925.11	CONTRACTUAL ALLOW	3,321,245.02
NON-COVERD CHARGES	504,660.42	TOTAL MEDICAID LIAB	1,943,680.09
		LESS: COB	17,119.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,926,561.00

TOTAL NUMBER OF ADMISSIONS 52

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,228		0	1,811,412.00		478,361.90
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,228		0	1,811,412.00		478,361.90
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,228		0	1,811,412.00		478,361.90

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 19:04:05  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER  
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	421,907.32	0.00	OTHER LAB	26,616.00	0.00
MED/SURG SUPPLY	275,326.25	14,407.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	481,002.00	5,917.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,291.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	144,644.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	142,164.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,938.00	0.00	MRI SERVICES	59,710.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,496.00	3,088.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	775,732.00	1,361.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,287.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,008.00	0.00	INJECTABLE DRUGS	634,101.54	1,019.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	195,016.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	110,108.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	41,238.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	30,060.00	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	6,234.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,347.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,250.00	506.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,819.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,218.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,453,513.11	26,298.52
			TOTAL ACCOMODATIONS	1,811,412.00	478,361.90
			TOTAL CHARGES	5,264,925.11	504,660.42

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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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WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	335,735.78	ADJUSTMENTS	479.39
COVERED CHARGES	298,936.78	CONTRACTUAL ALLOW	176,282.87
NON-COVERD CHARGES	36,799.00	TOTAL MEDICAID LIAB	122,653.91
		LESS: COB	601.08
		LESS: COPAYMENT	813.00
		REIMBURSEMENT	121,239.83
		ALL OTHER	120,647.01
		FEE SCHEDULE-LAB	592.42
		INJECTABLE DRUGS	0.40
		TOTAL NUMBER OF CLAIMS	295

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
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WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER  
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,610.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,313.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,505.00	2,828.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,874.00	629.00
EKG/ECG	354.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,966.00	33,111.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	24.78	231.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	717.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,329.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	54,393.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	153,781.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	298,936.78	36,799.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	298,936.78	36,799.00

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

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,356.00	ADJUSTMENTS	0.00
COVERED CHARGES	37,094.00	CONTRACTUAL ALLOW	7,933.57
NON-COVERD CHARGES	4,262.00	TOTAL MEDICAID LIAB	29,160.43
		LESS: COB	29,049.43
		LESS: COPAYMENT	111.00
		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

WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER  
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 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	215.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,414.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,011.00	500.00
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	2,087.00	2,348.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,912.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	19,205.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,546.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,094.00	4,262.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,094.00	4,262.00

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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WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
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WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
Run Time: 19:04:14  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 19:04:21  
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WALTON REHABILITATION HOSPITAL  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER 000368387A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,039,422.35	ADJUSTMENTS	0.00
COVERED CHARGES	1,009,325.35	CONTRACTUAL ALLOW	463,498.52
NON-COVERD CHARGES	30,097.00	TOTAL MEDICAID LIAB	545,826.83
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	545,826.83

TOTAL NUMBER OF ADMISSIONS 48

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	476		0	399,840.00		30,097.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	476		0	399,840.00		30,097.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	476		0	399,840.00		30,097.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WALTON REHABILITATION HOSPITAL  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222,734.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	75,050.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,782.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,923.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	103,137.00	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	6,024.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	119,610.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,321.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,904.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	609,485.35	0.00
			TOTAL ACCOMODATIONS	399,840.00	30,097.00
			TOTAL CHARGES	1,009,325.35	30,097.00

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

WALTON REHABILITATION HOSPITAL  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
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WALTON REHABILITATION HOSPITAL  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	123,749.00	ADJUSTMENTS	6,601.29
COVERED CHARGES	103,668.00	CONTRACTUAL ALLOW	65,197.12
NON-COVERD CHARGES	20,081.00	TOTAL MEDICAID LIAB	38,470.88
		LESS: COB	0.00
		LESS: COPAYMENT	624.00
		REIMBURSEMENT	37,846.88
		ALL OTHER	27,436.14
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	10,410.74

TOTAL NUMBER OF CLAIMS 198

WALTON REHABILITATION HOSPITAL  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,423.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,148.00	3,097.00	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	52.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,400.00	3,124.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,050.00	2,348.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	632.00	2,923.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,423.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,540.00	8,589.00			
			TOTAL ANCILLARY	103,668.00	20,081.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	103,668.00	20,081.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WALTON REHABILITATION HOSPITAL  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,612.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,876.00	CONTRACTUAL ALLOW	1,473.76
NON-COVERD CHARGES	736.00	TOTAL MEDICAID LIAB	2,402.24
		LESS: COB	2,402.24
		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

WALTON REHABILITATION HOSPITAL  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,600.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	276.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	736.00			
			TOTAL ANCILLARY	3,876.00	736.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,876.00	736.00

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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WALTON REHABILITATION HOSPITAL  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
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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WALTON REHABILITATION HOSPITAL  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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

WALTON REHABILITATION HOSPITAL  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
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

WALTON REHABILITATION HOSPITAL  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA  
 705 JUNIPER ST NE  
 ATLANTA,GA 30308-1307

PROVIDER NUMBER 000472513A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,531,801.43	ADJUSTMENTS	387,171.00
COVERED CHARGES	22,285,884.34	CONTRACTUAL ALLOW	16,177,208.49
NON-COVERD CHARGES	6,245,917.09	TOTAL MEDICAID LIAB	6,108,675.85
		LESS: COB	67,508.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,041,167.50

TOTAL NUMBER OF ADMISSIONS 148

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,512	1,152	3,172,410.00	4,161,018.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,512	1,152	3,172,410.00	4,161,018.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	703	0	1,433,337.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	703	0	1,433,337.00	0.00
TOTAL ACCOMODATIONS	4,215	1,152	4,605,747.00	4,161,018.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 19:04:36  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA  
 705 JUNIPER ST NE  
 ATLANTA,GA 30308-1307

PROVIDER NUMBER  
 000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,190,559.83	224.00	OTHER LAB	32,641.50	0.00
MED/SURG SUPPLY	2,618,193.90	2,244.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,311,880.61	11,075.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	253,614.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	106,428.00	5,957.09	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	209,144.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,284.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	518,832.00	2,092.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,244,843.00	1,979,636.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	84,609.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	2,443.00
RECOVERY ROOM	58,264.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	206,336.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	216,989.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	333,822.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,520.00
OTHER IMAGING SERVICE	7,986.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	211,476.00	71,708.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,045.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,189.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,680,137.34	2,084,899.09
			TOTAL ACCOMODATIONS	4,605,747.00	4,161,018.00
			TOTAL CHARGES	22,285,884.34	6,245,917.09

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 09/24/2013  
Run Time: 19:04:36  
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KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/11 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212195008003	05/23/12 - 07/11/12	07/16/12	0.00	9,520.00	0.00	0.00	0.00
TOTAL				0.00	9,520.00	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: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA  
 705 JUNIPER ST NE  
 ATLANTA,GA 30308-1307

PROVIDER NUMBER 000472513A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,303,272.54	ADJUSTMENTS	0.00
COVERED CHARGES	2,011,710.54	CONTRACTUAL ALLOW	1,974,881.88
NON-COVERD CHARGES	291,562.00	TOTAL MEDICAID LIAB	36,828.66
		LESS: COB	36,828.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	369		0	332,100.00		285,882.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	369		0	332,100.00		285,882.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	6,111.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,111.00		0.00
TOTAL ACCOMODATIONS	372		0	338,211.00		285,882.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA  
 705 JUNIPER ST NE  
 ATLANTA,GA 30308-1307

PROVIDER NUMBER  
 000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/11 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	305,375.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	220,700.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	188,620.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,922.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,560.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	736,974.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,634.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,054.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	184,443.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,216.00	5,680.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,673,499.54	5,680.00
			TOTAL ACCOMODATIONS	338,211.00	285,882.00
			TOTAL CHARGES	2,011,710.54	291,562.00



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: 09/24/2013  
Run Time: 19:04:39  
Page: 6

KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
Run Time: 19:04:39  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
Run Time: 19:04:39  
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KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
Run Time: 19:04:40  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/11	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 19:04:47  
 Page: 1

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,682,515.47	ADJUSTMENTS	126,978.44
COVERED CHARGES	7,354,261.97	CONTRACTUAL ALLOW	5,218,645.94
NON-COVERD CHARGES	328,253.50	TOTAL MEDICAID LIAB	2,135,616.03
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,135,616.03

TOTAL NUMBER OF ADMISSIONS 377

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,143		0	1,135,561.00		311,663.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2.00
TOTAL ROUTINE	1,143		0	1,135,561.00		311,665.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,143		0	1,135,561.00		311,665.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 19:04:47  
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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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	696,631.71	0.00	OTHER LAB	3,594.80	0.00
MED/SURG SUPPLY	261,194.10	600.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	428,186.24	330.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	84,557.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,067.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,253.90	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,456.10	0.00	MRI SERVICES	17,592.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,037.20	139.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,818,818.86	11,594.30	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	635,416.60	675.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	69,386.76	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,806.90	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,250.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,220.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63,685.90	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,794.30	0.00			
			TOTAL ANCILLARY	6,218,700.97	16,588.50
			TOTAL ACCOMODATIONS	1,135,561.00	311,665.00
			TOTAL CHARGES	7,354,261.97	328,253.50



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 19:05:05  
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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,821,332.16	ADJUSTMENTS	670,529.68
COVERED CHARGES	12,464,126.99	CONTRACTUAL ALLOW	8,601,114.18
NON-COVERD CHARGES	357,205.17	TOTAL MEDICAID LIAB	3,863,012.81
		LESS: COB	294.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,862,718.61
		ALL OTHER	3,565,418.80
		FEE SCHEDULE-LAB	201,672.96
		INJECTABLE DRUGS	95,626.85
		TOTAL NUMBER OF CLAIMS	11,914

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	395,731.23	1,252.19	OTHER LAB	153,307.90	4,976.00
MED/SURG SUPPLY	451,846.88	23.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	748.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	295,448.60	9,565.90	OTHER THERAPEUTIC SVC	0.00	840.00
CT SCAN	31,022.00	11,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,859,157.80	98,202.66
EKG/ECG	22,366.00	430.20	MRI SERVICES	2,344.00	2,185.00
IV THERAPY	2,784.90	0.00	PROFESSIONAL FEES	0.00	354.10
OPERATING ROOM	144,087.20	8,279.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,824,996.70	48,930.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,439,008.20	43,126.50	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	193,981.48	83,548.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,532,969.40	8,159.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	772.00
OTHER IMAGING SERVICE	71,596.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	892,182.50	34,211.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	402.00	0.00			
CARDIOLOGY	7,859.60	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	143,033.90	0.00			
			TOTAL ANCILLARY	12,464,126.99	357,205.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,464,126.99	357,205.17

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
Run Time: 19:05:05  
Page: 6

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3900	5913087000125	11/19/12 - 11/19/12	04/01/13	0.00	772.00	0.00	0.00	0.00
TOTAL				0.00	772.00	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: 09/24/2013  
Run Time: 19:08:03  
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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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,308.90	ADJUSTMENTS	0.00
COVERED CHARGES	12,184.70	CONTRACTUAL ALLOW	11,047.30
NON-COVERD CHARGES	124.20	TOTAL MEDICAID LIAB	1,137.40
		LESS: COB	1,137.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	296.40	5.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	317.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	415.80	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	2,429.60	119.00
EKG/ECG	260.30	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	933.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,891.50	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	640.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,184.70	124.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,184.70	124.20

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: 09/24/2013  
Run Time: 19:08:06  
Page: 9

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,494,444.70	ADJUSTMENTS	2,629.18
COVERED CHARGES	1,472,012.65	CONTRACTUAL ALLOW	1,367,237.03
NON-COVERD CHARGES	22,432.05	TOTAL MEDICAID LIAB	104,775.62
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	104,769.62
		TOTAL NUMBER OF CLAIMS	1,873

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,454.64	21.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,951.08	6.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,553.40	415.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,160.00	3,480.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	124,405.00	8,483.00
EKG/ECG	1,304.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,524.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,218.10	7,968.20	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	1,175,064.10	1,519.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	543.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,980.00	538.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,979.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,316.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,558.40	0.00			
			TOTAL ANCILLARY	1,472,012.65	22,432.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,472,012.65	22,432.05



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: 09/24/2013  
Run Time: 19:08:26  
Page: 11

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	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
Run Time: 19:08:28  
Page: 12

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 01/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,345.14	ADJUSTMENTS	12,922.06
COVERED CHARGES	73,937.42	CONTRACTUAL ALLOW	54,554.33
NON-COVERD CHARGES	19,407.72	TOTAL MEDICAID LIAB	19,383.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,383.09

TOTAL NUMBER OF CLAIMS 3

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 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,810.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,901.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	831.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,174.00	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	4,216.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,504.70	18,190.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,042.90	928.60	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	353.12	229.02
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,544.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,558.40	0.00			
			TOTAL ANCILLARY	73,937.42	19,407.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,937.42	19,407.72

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: 09/24/2013  
Run Time: 19:08:31  
Page: 14

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	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 19:08:41  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,751.74	ADJUSTMENTS	0.00
COVERED CHARGES	28,464.74	CONTRACTUAL ALLOW	8,456.05
NON-COVERD CHARGES	1,287.00	TOTAL MEDICAID LIAB	20,008.69
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,008.69

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		2	4,248.00		1,287.00
ROUTINE NURSERY	0		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		2	4,248.00		1,287.00
SPECIAL CARE SERVICES						
CCU	2		0	1,320.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	1,320.00		0.00
TOTAL ACCOMODATIONS	10		2	5,568.00		1,287.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,948.61	0.00	OTHER LAB	550.00	0.00
MED/SURG SUPPLY	2,523.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,122.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	294.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,107.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	640.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	275.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	937.08	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	500.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,896.74	0.00
			TOTAL ACCOMODATIONS	5,568.00	1,287.00
			TOTAL CHARGES	28,464.74	1,287.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
Run Time: 19:08:42  
Page: 3

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 07/01/11 THROUGH 06/30/12  
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: 09/24/2013  
Run Time: 19:08:42  
Page: 4

MORGAN MEMORIAL HOSPITAL  
1077 S MAIN ST  
MADISON,GA 30650-2073

PROVIDER NUMBER  
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	426,254.23	ADJUSTMENTS	11,515.42
COVERED CHARGES	377,479.22	CONTRACTUAL ALLOW	218,322.14
NON-COVERD CHARGES	48,775.01	TOTAL MEDICAID LIAB	159,157.08
		LESS: COB	0.00
		LESS: COPAYMENT	339.00
		REIMBURSEMENT	158,818.08
		ALL OTHER	146,079.96
		FEE SCHEDULE-LAB	12,645.55
		INJECTABLE DRUGS	92.57

TOTAL NUMBER OF CLAIMS 524



Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 09/24/2013  
 Run Time: 19:08:42  
 Page: 5

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,260.19	9,132.92	OTHER LAB	2,566.00	0.00
MED/SURG SUPPLY	7,091.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,525.00	294.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,919.00	11,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	110,649.00	21,891.75
EKG/ECG	8,460.30	0.00	MRI SERVICES	7,500.00	1,500.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	48.00
OPERATING ROOM	5,747.36	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,077.00	6.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,526.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	117,613.26	1,150.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,259.11	3,144.56
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	2,466.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,712.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,213.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,143.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,752.00	0.00			
			TOTAL ANCILLARY	377,479.22	48,775.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	377,479.22	48,775.01

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MORGAN MEMORIAL HOSPITAL  
1077 S MAIN ST  
MADISON,GA 30650-2073

PROVIDER NUMBER  
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,765.12	ADJUSTMENTS	0.00
COVERED CHARGES	3,281.44	CONTRACTUAL ALLOW	721.79
NON-COVERD CHARGES	483.68	TOTAL MEDICAID LIAB	2,559.65
		LESS: COB	2,559.65
		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

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36.00	67.68	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	54.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	294.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,569.00	416.00
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	141.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	930.88	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,281.44	483.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,281.44	483.68

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: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,096.95	ADJUSTMENTS	146.99
COVERED CHARGES	26,383.17	CONTRACTUAL ALLOW	22,983.17
NON-COVERD CHARGES	3,713.78	TOTAL MEDICAID LIAB	3,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	123.01
		REIMBURSEMENT	3,276.99
		TOTAL NUMBER OF CLAIMS	68

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	756.89	1,443.45	OTHER LAB	486.00	0.00
MED/SURG SUPPLY	208.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,634.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,563.00	1,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,025.00	377.00
EKG/ECG	128.00	0.00	MRI SERVICES	1,700.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,731.84	75.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	61.76	211.33
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	26,383.17	3,713.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,383.17	3,713.78

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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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,956.67	ADJUSTMENTS	12,900.72
COVERED CHARGES	33,238.67	CONTRACTUAL ALLOW	20,337.95
NON-COVERD CHARGES	5,718.00	TOTAL MEDICAID LIAB	12,900.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,900.72

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,757.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,448.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	320.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,039.00	FEE SCHEDULE LAB	6,385.00	204.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	328.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	672.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	196.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,238.67	5,718.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,238.67	5,718.00



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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
 Run Time: 19:09:04  
 Page: 1

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,055,126.53	ADJUSTMENTS	830,185.42
COVERED CHARGES	14,902,929.13	CONTRACTUAL ALLOW	10,780,489.13
NON-COVERD CHARGES	152,197.40	TOTAL MEDICAID LIAB	4,122,440.00
		LESS: COB	60,653.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,061,786.48

TOTAL NUMBER OF ADMISSIONS 515

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,629		0	1,425,375.00		73,305.00
ROUTINE NURSERY	294		0	270,460.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,923		0	1,695,835.00		73,305.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	358		0	848,090.00		0.00
NICU	313		0	674,515.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	671		0	1,522,605.00		0.00
TOTAL ACCOMODATIONS	2,594		0	3,218,440.00		73,305.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL  
 1255 HIGHWAY 54 W  
 FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
 000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,869,513.98	423.75	OTHER LAB	76,040.00	0.00
MED/SURG SUPPLY	382,139.55	5,552.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,933,234.09	5,772.00	EDUCATION & TRAINING	2,540.00	0.00
RADIOLOGY-DIAGNOSTIC	451,107.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,018,597.00	1,405.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	110,825.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	111,720.00	0.00	MRI SERVICES	198,828.00	0.00
IV THERAPY	2,096.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	744,129.00	1,362.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	192,147.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	757,739.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	136,758.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	153,181.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	720,652.00	4,736.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	179,539.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	67,987.00	0.00	INJECTABLE DRUGS	7,869.50	592.00
RADIOLOGY THERAPEUTIC	40,499.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	66,362.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	31,589.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	144,270.00	32,060.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	848.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	256,965.60	6,889.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	223,329.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	224,075.00	4,815.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	90,795.00	14,437.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	442,432.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	21,662.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,868.41	0.00			
			TOTAL ANCILLARY	11,684,489.13	78,892.40
			TOTAL ACCOMODATIONS	3,218,440.00	73,305.00
			TOTAL CHARGES	14,902,929.13	152,197.40

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 19:09:25  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL  
 1255 HIGHWAY 54 W  
 FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
 000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	324,382.85	ADJUSTMENTS	0.00
COVERED CHARGES	322,942.85	CONTRACTUAL ALLOW	189,796.06
NON-COVERD CHARGES	1,440.00	TOTAL MEDICAID LIAB	133,146.79
		LESS: COB	133,146.79
		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	32		0	28,000.00		1,440.00
ROUTINE NURSERY	11		0	9,010.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	43		0	37,010.00		1,440.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	5,260.00		0.00
NICU	6		0	12,930.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	18,190.00		0.00
TOTAL ACCOMODATIONS	51		0	55,200.00		1,440.00

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,537.45	0.00	OTHER LAB	1,590.00	0.00
MED/SURG SUPPLY	18,730.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,414.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,367.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,442.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,342.00	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	54,847.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,711.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,618.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,634.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,356.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,012.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,011.00	0.00	INJECTABLE DRUGS	1,965.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	880.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	306.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	59,851.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,807.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,896.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	426.00	0.00			
			TOTAL ANCILLARY	267,742.85	0.00
			TOTAL ACCOMODATIONS	55,200.00	1,440.00
			TOTAL CHARGES	322,942.85	1,440.00

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: 09/24/2013  
Run Time: 19:09:27  
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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,928,966.41	ADJUSTMENTS	251,712.19
COVERED CHARGES	10,584,686.89	CONTRACTUAL ALLOW	8,427,533.15
NON-COVERD CHARGES	1,344,279.52	TOTAL MEDICAID LIAB	2,157,153.74
		LESS: COB	25,026.31
		LESS: COPAYMENT	3,570.00
		REIMBURSEMENT	2,128,557.43
		ALL OTHER	1,943,132.95
		FEE SCHEDULE-LAB	126,978.29
		INJECTABLE DRUGS	58,446.19

TOTAL NUMBER OF CLAIMS 3,842

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	404,184.20	3,230.00	OTHER LAB	98,379.00	530.00
MED/SURG SUPPLY	405,128.79	16.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	194.00	EDUCATION & TRAINING	4,631.00	0.00
RADIOLOGY-DIAGNOSTIC	661,081.00	17,316.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,388,819.00	253,756.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,808.00	16,212.00	FEE SCHEDULE LAB	1,428,049.26	155,041.00
EKG/ECG	169,140.00	870.00	MRI SERVICES	245,787.00	17,537.00
IV THERAPY	23,518.00	19,052.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	809,113.00	193,764.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	89,031.00	0.00	REHAB THERAPY	79.00	0.00
RESPIRATORY SERVICES	36,884.00	15,699.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	141,369.00	2,565.00	AMBULANCE	0.00	0.00
GI SERVICES	375,485.00	64,408.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,991,144.00	87,219.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	232,223.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	367,360.64	190,936.96
RADIOLOGY THERAPEUTIC	177,318.00	1,354.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,597.00	3,841.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,087.00	714.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,580.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	55,455.00	5,760.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,770.35	72,106.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	448,283.00	76,190.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,954.00	26,423.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	175,306.00	30,369.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	385,038.00	66,584.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	119,049.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	240,615.65	18,012.20			
			TOTAL ANCILLARY	10,584,686.89	1,344,279.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,584,686.89	1,344,279.52

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	447,212.05	ADJUSTMENTS	0.00
COVERED CHARGES	319,203.35	CONTRACTUAL ALLOW	154,746.24
NON-COVERD CHARGES	128,008.70	TOTAL MEDICAID LIAB	164,457.11
		LESS: COB	164,361.11
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 135



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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,755.00	468.60	OTHER LAB	1,982.00	0.00
MED/SURG SUPPLY	17,761.50	18.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	684.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,738.00	394.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,622.00	29,836.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,183.00	0.00	FEE SCHEDULE LAB	40,476.16	5,089.80
EKG/ECG	3,770.00	0.00	MRI SERVICES	6,316.00	5,133.00
IV THERAPY	6,040.00	3,120.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,363.00	46,616.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,216.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	448.00	140.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,254.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,454.00	2,503.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,296.00	4,283.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,293.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,289.00	2,270.30
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	2,384.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	477.00	1,244.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	677.00
OTHER IMAGING SERVICE	7,563.00	14,907.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,516.00	1,578.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,007.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,919.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,087.69	5,200.00			
			TOTAL ANCILLARY	319,203.35	126,168.70
			TOTAL ACCOMODATIONS	0.00	1,840.00
			TOTAL CHARGES	319,203.35	128,008.70

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL  
1255 HIGHWAY 54 W  
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9928	2212094013040	01/28/12 - 01/28/12	04/09/12	0.00	677.00	0.00	832.84	0.00
TOTAL				0.00	677.00	0.00	832.84	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: 09/24/2013  
Run Time: 19:10:42  
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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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	420,714.60	ADJUSTMENTS	1,085.80
COVERED CHARGES	407,226.90	CONTRACTUAL ALLOW	385,745.94
NON-COVERD CHARGES	13,487.70	TOTAL MEDICAID LIAB	21,480.96
		LESS: COB	0.00
		LESS: COPAYMENT	615.02
		REIMBURSEMENT	20,865.94
		TOTAL NUMBER OF CLAIMS	384

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 09/24/2013  
 Run Time: 19:10:42  
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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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,422.45	9.00	OTHER LAB	4,418.00	0.00
MED/SURG SUPPLY	1,023.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,378.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,141.00	2,369.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67,592.00	6,384.00
EKG/ECG	13,340.00	0.00	MRI SERVICES	5,133.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	199,667.00	2,064.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,178.00	97.70
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	17,486.00	2,564.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	407,226.90	13,487.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	407,226.90	13,487.70

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: 09/24/2013  
Run Time: 19:10:51  
Page: 12

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 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,534.50	ADJUSTMENTS	0.00
COVERED CHARGES	25,455.50	CONTRACTUAL ALLOW	15,666.39
NON-COVERD CHARGES	4,079.00	TOTAL MEDICAID LIAB	9,789.11
		LESS: COB	9,780.11
		LESS: COPAYMENT	9.00
		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

Run Date: 09/24/2013  
 Run Time: 19:10:51  
 Page: 13

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	531.50	0.00	OTHER LAB	898.00	0.00
MED/SURG SUPPLY	93.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,036.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,369.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,779.00	1,515.00
EKG/ECG	580.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,141.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,564.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,455.50	4,079.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,455.50	4,079.00

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: 09/24/2013  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL  
1255 HIGHWAY 54 W  
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/11 THROUGH 06/30/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,845,526.61	ADJUSTMENTS	42,378.08
COVERED CHARGES	1,752,744.21	CONTRACTUAL ALLOW	1,541,403.87
NON-COVERD CHARGES	92,782.40	TOTAL MEDICAID LIAB	211,340.34
		LESS: COB	0.00
		LESS: COPAYMENT	645.00
		REIMBURSEMENT	210,695.34
		TOTAL NUMBER OF CLAIMS	40

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 07/01/11 THROUGH 06/30/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,931.60	1,780.60	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	49,961.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,411.00	2,363.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	201,647.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	523.00	FEE SCHEDULE LAB	23,744.00	2,714.00
EKG/ECG	2,900.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	52,808.00	108.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	134,752.00	1,114.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	851.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	363.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,520.00	4,845.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,232.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,054.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	495,469.44	34,599.80
RADIOLOGY THERAPEUTIC	479,811.00	5,662.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	396.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	99,438.60	28,724.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	351.00	1,182.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,834.00	1,578.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,923.00	294.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	109,028.00	7,295.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,318.20	0.00			
			TOTAL ANCILLARY	1,752,744.21	92,782.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,752,744.21	92,782.40



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: 09/24/2013  
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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	07/01/11	THROUGH	06/30/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

THE SPECIALTY HOSPITAL  
 320 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER 000886179A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,184,399.70	ADJUSTMENTS	61,156.93
COVERED CHARGES	630,404.70	CONTRACTUAL ALLOW	356,379.92
NON-COVERD CHARGES	553,995.00	TOTAL MEDICAID LIAB	274,024.78
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	274,024.78

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	17		205	10,710.00		489,825.00
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	17		205	10,710.00		489,825.00
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	17		205	10,710.00		489,825.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL  
 320 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER  
 000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160,253.70	0.00	OTHER LAB	1,368.00	0.00
MED/SURG SUPPLY	158,066.50	128.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	71,702.00	690.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,652.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,785.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,496.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,640.00	0.00	MRI SERVICES	5,861.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,708.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107,057.00	63,052.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,020.00	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	13,523.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,622.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	300.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	578.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,932.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,065.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,365.50	0.00			
			TOTAL ANCILLARY	619,694.70	64,170.00
			TOTAL ACCOMODATIONS	10,710.00	489,825.00
			TOTAL CHARGES	630,404.70	553,995.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
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THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
Run Time: 19:11:05  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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 SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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: 09/24/2013  
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SUMMARY TYPE I  
INPATIENT PAID CLAIMS

SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SELECT SPECIALTY HOSPITAL ATLANTA  
 550 PEACHTREE ST NE 7TH FL  
 ATLANTA,GA 30308-2247

PROVIDER NUMBER  
 000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,123.03	ADJUSTMENTS	0.00
COVERED CHARGES	86,083.03	CONTRACTUAL ALLOW	50,253.06
NON-COVERD CHARGES	8,040.00	TOTAL MEDICAID LIAB	35,829.97
		LESS: COB	35,829.97
		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	24		0	20,040.00		8,040.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	24		0	20,040.00		8,040.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	20,040.00		8,040.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SELECT SPECIALTY HOSPITAL ATLANTA  
 550 PEACHTREE ST NE 7TH FL  
 ATLANTA,GA 30308-2247

PROVIDER NUMBER  
 000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,415.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,470.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,426.51	0.00	EDUCATION & TRAINING	301.30	0.00
RADIOLOGY-DIAGNOSTIC	535.52	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	887.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,325.00	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	35,047.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	541.65	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,092.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	66,043.03	0.00
			TOTAL ACCOMODATIONS	20,040.00	8,040.00
			TOTAL CHARGES	86,083.03	8,040.00

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: 09/24/2013  
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SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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

Run Date: 09/24/2013  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 12/31/12  
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: 09/24/2013  
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SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER 344886600A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,069,474.96	ADJUSTMENTS	207,225.17
COVERED CHARGES	3,024,859.66	CONTRACTUAL ALLOW	1,940,599.18
NON-COVERD CHARGES	44,615.30	TOTAL MEDICAID LIAB	1,084,260.48
		LESS: COB	22,497.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,061,762.57

TOTAL NUMBER OF ADMISSIONS 128

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	363		0	404,541.00		18,354.00
ROUTINE NURSERY	44		0	36,725.00		107.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	407		0	441,266.00		18,461.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	175		0	707,925.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	175		0	707,925.00		0.00
TOTAL ACCOMODATIONS	582		0	1,149,191.00		18,461.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242,511.54	8.09	OTHER LAB	8,112.00	0.00
MED/SURG SUPPLY	198,521.00	2,481.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	157,245.65	452.00	EDUCATION & TRAINING	90.00	0.00
RADIOLOGY-DIAGNOSTIC	47,812.00	0.00	OTHER THERAPEUTIC SVC	0.00	14,503.00
CT SCAN	65,950.00	1,367.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,905.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,238.00	0.00	MRI SERVICES	28,323.00	0.00
IV THERAPY	31,411.00	326.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	269,809.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	46,022.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,238.00	1,962.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,329.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	35,544.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	79,269.00	75.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,239.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,004.00	0.00	INJECTABLE DRUGS	196,174.27	23.21
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,941.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,538.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	24,948.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,534.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,571.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,218.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,169.00	1,658.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,539.00	1,916.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	163,472.00	1,383.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,456.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,534.70	0.00			
			TOTAL ANCILLARY	1,875,668.66	26,154.30
			TOTAL ACCOMODATIONS	1,149,191.00	18,461.00
			TOTAL CHARGES	3,024,859.66	44,615.30

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,973.83	ADJUSTMENTS	0.00
COVERED CHARGES	43,631.83	CONTRACTUAL ALLOW	21,873.20
NON-COVERD CHARGES	342.00	TOTAL MEDICAID LIAB	21,758.63
		LESS: COB	21,758.63
		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	6		0	6,648.00		342.00
ROUTINE NURSERY	6		0	15,450.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	22,098.00		342.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	22,098.00		342.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,851.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	616.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,259.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,169.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,312.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,154.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	280.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	401.00	0.00	INJECTABLE DRUGS	491.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,533.83	0.00
			TOTAL ACCOMODATIONS	22,098.00	342.00
			TOTAL CHARGES	43,631.83	342.00

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: 09/24/2013  
Run Time: 19:11:20  
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EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,078,150.76	ADJUSTMENTS	17,857.24
COVERED CHARGES	965,643.24	CONTRACTUAL ALLOW	715,000.72
NON-COVERD CHARGES	112,507.52	TOTAL MEDICAID LIAB	250,642.52
		LESS: COB	389.10
		LESS: COPAYMENT	795.00
		REIMBURSEMENT	249,458.42
		ALL OTHER	219,405.52
		FEE SCHEDULE-LAB	14,543.41
		INJECTABLE DRUGS	15,509.49

TOTAL NUMBER OF CLAIMS 526



EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,072.46	0.00	OTHER LAB	10,835.00	0.00
MED/SURG SUPPLY	48,081.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,089.00	501.00	OTHER THERAPEUTIC SVC	0.00	456.00
CT SCAN	50,730.00	27,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,280.00	3,076.00	FEE SCHEDULE LAB	64,239.25	14,644.60
EKG/ECG	4,151.00	87.00	MRI SERVICES	52,517.00	5,489.00
IV THERAPY	71,005.25	2,850.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	137,916.50	14,445.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,280.00	1,152.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,036.00	349.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,157.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,695.00	5,511.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	196,832.00	709.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,978.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	51,682.13	4,464.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	248.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,112.00	148.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,894.00	2,787.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,502.00	2,768.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,871.00	401.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,333.00	5,365.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	65,784.00	19,660.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,850.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,720.65	0.00			
			TOTAL ANCILLARY	965,643.24	112,507.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	965,643.24	112,507.52

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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,042.96	ADJUSTMENTS	0.00
COVERED CHARGES	31,359.58	CONTRACTUAL ALLOW	11,640.53
NON-COVERD CHARGES	6,683.38	TOTAL MEDICAID LIAB	19,719.05
		LESS: COB	19,695.05
		LESS: COPAYMENT	24.00
		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

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,524.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,197.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	884.00	217.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	783.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,584.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,428.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,162.50	2,173.50	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	483.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,572.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	612.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45.92	3,147.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	194.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	173.00	362.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,500.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	31,359.58	6,683.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,359.58	6,683.38

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: 09/24/2013  
Run Time: 19:11:28  
Page: 9

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,854.58	ADJUSTMENTS	49.93
COVERED CHARGES	31,134.74	CONTRACTUAL ALLOW	29,456.54
NON-COVERD CHARGES	1,719.84	TOTAL MEDICAID LIAB	1,678.20
		LESS: COB	0.00
		LESS: COPAYMENT	45.01
		REIMBURSEMENT	1,633.19
		TOTAL NUMBER OF CLAIMS	30

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	775.78	0.00	OTHER LAB	0.00	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	1,063.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,790.00	1,111.00
EKG/ECG	379.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,591.00	114.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,809.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46.26	132.84
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	897.00	362.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	679.70	0.00			
			TOTAL ANCILLARY	31,134.74	1,719.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,134.74	1,719.84

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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Page: 11

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	08/31/12
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 JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/12 THROUGH 08/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	176,813.07	ADJUSTMENTS	0.00
COVERED CHARGES	164,410.07	CONTRACTUAL ALLOW	138,593.77
NON-COVERD CHARGES	12,403.00	TOTAL MEDICAID LIAB	25,816.30
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	25,798.30

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/12 THROUGH 08/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,778.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,131.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	334.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,282.00	464.00
EKG/ECG	348.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,266.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	24,321.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,985.00	11,939.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	362.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	84,825.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	776.80	0.00			
			TOTAL ANCILLARY	164,410.07	12,403.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	164,410.07	12,403.00



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: 09/24/2013  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/12	THROUGH	08/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*